

S
351.842 Montana. Mental
M34rmsh Disabilities Board
1987 of Visitors
[Board of
Visitors review of
Montana State
Hospital, fiscal

BOARD OF VISITORS

ON-SITE REVIEW

STATE MENTAL HOSPITAL

STATE DOCUMENTS COLLECTION

SEP -7 1994

MONTANA STATE LIBRARY
1915 E. 6th AVE.
HELENA, MONTANA 59620

PLEASE RETURN

MONTANA STATE LIBRARY

S 351.842 M34meh 1997 c.1

[Board of Visitors review of Montana Sta



3 0864 00090547 4

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS



TED SCHWINDEN GOVERNOR

CHAPTER 1

STATE OF MONTANA

(406) 444 3955

HELENA, MONTANA 59601

This report of the Mental Disabilities Board of Visitors summarizes the 1987 Fiscal Year on-site review of Montana State Hospital. In accord with the Mental Commitment and Treatment Act of 1975, the Warm Springs and Galen campuses were reviewed with regard to staffing, treatment services, consumer issues, record keeping, the physical environment and medications. Information for this report is based on a random review of client files, direct observations of patient care, interviews with the patients and all levels of staff at the facility.

This report, prepared for the Honorable Governor of the State of Montana, will also be sent to the Superintendent of Montana State Hospital and to the Director of the Department of Institutions. Highlights of this report will be made part of the annual report of the Board of Visitors to the Honorable Governor of the State of Montana.

BOARD OF VISITORS
REVIEW OF
MONTANA STATE HOSPITAL
FISCAL YEAR 1987

OVERVIEW AND STAFFING

One of the major responsibilities of Montana State Hospital is to provide care and treatment for the seriously mentally ill residents of the state of Montana. By virtue of the definition of seriously mentally ill, these individuals need more intensive treatment services than are available in community settings.

Montana State Hospital is not licensed as a psychiatric facility, nor is it accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). Sixty beds at the Warm Springs campus (Spratt 219) are licensed for nursing care and 155 beds at Galen are licensed as an acute hospital and intermediate care.

The average daily population at the Warm Springs campus during fiscal year 1986 was 301. There were 486.25 full time equivalent positions authorized for the Warm Springs campus during this time. The current economics of the State resulted in

laying off 2.6 positions and freezing 14.71 positions.

ACCOMPLISHMENTS

1. Social Service and Pre-Release unit staff have had opportunities to review community programs and group homes in Butte, Missoula, Great Falls and Billings. This is important in coordinating discharge planning, and the social workers at the Warm Springs Campus are to be commended for the community contacts and networking they have established.

2. Efforts are being made to increase communication between administration and staff. Weekly meetings are held with the cabinet and the treatment supervisors. The Board views these undertakings as an important first step in maintaining ongoing efforts to hear, observe, and act on the concerns of all levels of staff.

Plans are being formulated to establish a committee of all levels of staff to evaluate the hospital needs. This is a positive step and the outcome will be beneficial if staff members feel their viewpoints and input have meaning and are taken seriously.

3. Despite the odds, it is important to note that staff members are caring, dedicated individuals. They know their patients and care for them in a personal manner and are concerned about their well being.

4. Staff Development has prepared an information booklet

for staff outlining personnel policies, ethics, job responsibilities and charting. This promises to be an invaluable tool, especially for new staff.

DEFICIENCIES

1. The treatment staff vacancies at Montana State Hospital translate to an increase in liabilities for the State hospital and the State of Montana. These shortcomings include: 1) a higher risk of injuries to patients and staff; 2) crisis intervention becomes the primary therapy when there is not enough treatment staff to consistently provide individual and group therapy; 3) the length of stay increases and 4) higher risk of law suits due to lack of adequate psychological treatment, prompt medical attention and nursing care.

The repercussions of staff shortage on patient care are unending. Weekend treatment services and activities are extremely limited. If a treatment staff member is sick or on vacation, there are no replacements; if a direct care staff is sick, flex positions may or may not be available. When a housekeeper is off, a ward may go without a thorough cleaning. The direct care staff has had to perform basic housekeeping duties, thereby further limiting their time with other patient needs.

There is a specific need for one additional Security Duty Aide for each shift on the Forensic Unit. Unit 86 which houses "extreme behavior problems" clearly has a dangerous understaffing problem. There is high incidence of injuries to staff

and patients (all of which have been documented). Although highly motivated and understanding, the existing staff is spread too thin, needs additional back-up, and continues to operate in a dangerous situation.

2. At the time of the Board's review only two of six psychiatrists positions were filled. The workload and demands placed on only two psychiatrists is intolerable. The Department of Institutions reports that a National Health Corp psychiatrist will join the staff in July of 1987 and since January arrangements have been made for a rotating contract psychiatrist to serve at the hospital.

Recruiting psychiatrists for Montana has been an on-going problem. In order to attract competent, licensed psychiatrists we must offer salaries to attract such individuals. The salary range of \$63,000 does not rival surrounding states who are offering \$76,000 to \$120,000. The Board of Visitors supports a higher salary range for the psychiatrists and the Department of Institutions in their recruitment efforts.

3. There are seven authorized psychologist positions at the hospital. Since December however there have been only three and a half psychologists for three hundred patients. These positions are crucial because psychologists are responsible for the development and implementation of group and individual therapy. In addition they are responsible for testing, evaluations, developing treatment plans and diagnostic impressions. Recruitment problems in this area appear to include salary.

4. Because of the pharmacist vacancy the hospital is considering contracting out the services. According to the Board's consultants this could be done, but it will not result in any better service than could be done if competitive salaries were offered to the pharmacist.

5. Inservice training funds are inadequate. In order to provide active treatment services, based on the needs of the patients, there is a real need to provide new information and skills to direct care and professional staff. The staff at Montana State Hospital is faced with treating a most challenging patient population. Maintaining and building the expertise of the treatment staff will improve patient care and reduce staff turnover. Alternatives of providing additional in-service and funding sources must be explored.

The Board's consultants suggested an aggressive in-service training program be implemented in addition to what is currently being provided. They suggest senior treatment staff regularly schedule time with aides to upgrade their skills by examining and studying specific patient problems. Discussions of "real" clinical issues will be more relevant to psychiatric aides and the patients under their care.

6. The wide variety of patient needs warrants an increase in treatment and developmental staff at Montana State Hospital. Persons trained in treating sex offenders, behavior problems, brain-injured individuals and the young adult schizophrenic are needed.

The Forensic Unit has an occupancy rate of 93.89% . At the time of our site review there was a waiting list of ten individuals. With the completion of the new building, it is imperative that the unit be adequately staffed with both direct care and professionals.

7. A lack of certified mental health professionals [53-21-102(10)(B) and 53-21-106 M.C.A.] on each unit often requires calling staff from other units to approve and document situations which require the use of restraints and/or seclusion. The certification of 'limited mental health professionals' by the Department of Institutions may help part of this problem. There is, however, no incentive for professionals to request this certification.

8. There continues to be several areas within both the Warm Springs and Galen campus where patients and staff would benefit from volunteers. These include the library, donations, recreation, education, and community outings. This community resource remains untapped and it has infinite possibilities.

9. Although there are computers at the Warm Springs campus, they are not all in operation. Without the necessary software, programmer time and access, these machines are useless. Many projects, including inventories, maintenance schedules, lab reports, etc. could be completed in a more timely and efficient manner if the training was provided to make the computers operational.

**TREATMENT SERVICES [53-21-101, 53-21-104, 53-21-162, MONTANA
CODES ANNOTATED, 1985]**

The treatment units at Warm Springs include: Intake, Intensive Treatment, Extended Treatment, Long-Term, Forensic, Pintlar Lodge (men and women's) and the Pre-Release Unit. The Galen facility provides services to: a) long term elderly psychiatric patients; b) acute medical patients from the Warm Springs campus; c) persons suffering from respiratory and lung problems and d) persons suffering from chemical dependency. The functions and goals of the various units have been described in previous reports of the Board of Visitors.

ACCOMPLISHMENTS

5. The resident employment program serves over one hundred patients at the Warm Springs campus. This program is efficient in its' service to the residents.

6. Good working relationships have been established with the Aftercare programs of the community mental health centers and mental health residential settings. Quarterly meetings are held with Warm Springs staff and representatives from the mental health centers to review admissions and discharges to the hospital.

7. The vocational-educational program at Montana State Hospital serves over 100 residents. The program provides general

education, G.E.D. training, home economics, carpentry, and automotive training. The residents receive training to increase their basic life/survival skills, attention span and concentration abilities. Fourteen residents, this year, have completed their G.E.D.

The Board and its consultants urge the unit treatment teams and the rehabilitation staff to work in conjunction with one another. Rehabilitation is important for residents in preparing for discharge from the State hospital.

8. Increased activities for the elderly residents at Galen include shopping trips, trips to the canteen at Warm Springs, and recreational outings. The hospital staff is to be complimented for making these opportunities available.

9. The Recreation Department serves all the patients at Montana State Hospital. The wide range of indoor and outdoor activities is very beneficial to the residents. One unique program taught over sixty patients to learn to swim. Various seasonal programs include coordinating the Gifts With A Lift Program, the Christmas Talent Show, the Summer Carnival, and special dances.

10. Staff from the Pre-Release Unit is well acquainted with community resources, such as community mental health centers, group homes, and day treatment programs. They have demonstrated effective communication with the mental health centers staff.

11. The staff of the Geriatric unit has remarkable knowledge of each patient. They are aware of the effect of environmental

stimulus on each patient and are sensitive to the slight changes in behavior. The treatment approach is behavioral and of course, pharmacological. There is little evidence of psychodynamic intervention, however this is acceptable given the age, chronicity and organicity of the patients. All staff used redirection, limit setting and reality orientation. The Board's consultants observed staff members intervene with an escalating patient and effectively diffuse a potentially volatile situation.

12. Within the last year individual therapy has been made available for the residents on the Maximum Security Unit. This is an important start.

A very important dimension of service offered on the Forensic Unit is the Activity and Recreation program. By the very nature of admission to the Forensic Unit, a patient will experience a high degree of security and confinement. The variety of activities is therefore very important. They include: exercise, crafts, movies, current events groups, etc.

13. The program in the Pintlar and Pre-Release units is basically educationally oriented, with an open ward policy. In addition the hospital has included four women in the Pintlar program. Community living skills, which include apartment seeking, consumer counseling, job seeking and leisure counseling are offered four hours a week. Other programs include home economics, a self-medication program, rehabilitation therapy and occupational therapy.

14. Since the Board's last review all the patients on the Extended Treatment Unit have been re-evaluated psychologically. (Luria Nebraska Psychoneurological Battery). Plans are being made to incorporate these results into the treatment plans.

15. The Board's consultant observed the treatment offered to case 33596 was appropriate. Prior to placement at Galen, this young adult was housed on the Maximum Security Unit. The progress notes at Galen indicate frequent contact is provided by the recreation department and nursing staff. The care plan carefully identifies treatment approaches. It appears the individual is handled in a gentle, but firm fashion, which would be warranted by his defects. The Board's consultant concurred that Galen is the most appropriate placement at this time.

16. The elderly patients on the Long Term Unit, Crockett I and Terrill I were out-of-bed. Those that were non-ambulatory were in Geri chairs or lounge chairs. The ward areas, however, would benefit from additional pictures, magazines, etc. which would help provide stimulation.

DEFICIENCIES

10. For the most part the current treatment focus at Montana State Hospital is chemotherapy and a combination of activities and recreation. Psychotherapy, both individual and group, is minimal.

Group and individual therapy opportunities are inadequate.

Scheduled group therapy on the units at Warm Springs varied from none for some patients, to an average of two to three hours per week for others. Individual therapy depends upon the availability of staff. These treatment services need professional staff to serve as primary therapists and provide clinical supervision.

For patients diagnosed as schizophrenic (which are housed on all units) the professional literature indicates that, chemotherapy alone is not as effective as chemotherapy plus psychotherapy. Problem solving and social skill enhancement can not be addressed by chemotherapy alone.

The extent and quality of psychotherapy offered at Warm Springs is marginal at best as a result of 1) staff cutbacks, 2) lack of supervisory staff and 3) lack of continuing education. As noted in past reviews many of the staff who are running groups do not have formal training or experience. This problem continues and in some cases has worsened. The staff deserves recognition for their willingness to proceed under these circumstances, nevertheless, the problem must not be overlooked. The Board's consultants expressed concern over the lack of clinical supervision. The State hospital population is the most difficult and challenging group of individuals requiring mental health treatment. Yet an ongoing review of cases, of problem individuals or those with conflicting opinions about diagnosis (which would dictate different types of treatment) is virtually non-existent. Case 37416 is an example of this difficulty. In nine admissions the diagnostic formulation has varied from

schizophrenia to borderline personality disorder with transient psychotic episodes. The use and type of chemotherapy and the type of psychotherapy would vary depending on the appropriate diagnosis.

11. There are inadequate treatment services specific to the young chronically mentally ill. Population trends show over thirty per cent of admissions are between the ages of twenty-one to thirty. Approximately sixty per cent of admissions fall between the ages of twenty-one to forty. Services to this young population must become a priority for the hospital.

12. The Board's consultants observed a substantial proportion of the young chronic population with a dual diagnosis of substance abuse and a psychotic disorder. The substance abuse problems are not addressed directly while the patient is at Warm Springs, however this is frequently a factor in a failed community placement. The addition of chemical dependency education would seem essential. This, of course, requires the addition of personnel trained in the chemical dependency field and those who are able to apply their knowledge with individuals who are seriously mentally ill. Some individual referrals are made to the Alcohol and Drug program at the Galen campus, but follow-up services and regularly scheduled opportunities to address this problem are needed.

13. Although there are a number of individuals who have been identified as sex offenders, there is no treatment program for this population.

14. Treatment plans must identify the goals and an integrated balanced program of activities, therapies and treatment to help the residents return to the community. The Board observed that many activities are available for the patients, but the number of treatment opportunities is limited.

Scheduled group therapy on the various units at Warm Springs averages less than three hours per week. Individual therapy depends upon what staff are available and this ranges from psychiatric aides, nurses and occasionally social workers. Some group therapy is provided by people who have not been professionally trained in the dynamics of group therapy, psychology, etc. Direct care staff not properly trained should not conduct group therapy.

15. Case 46682 has been evaluated several times, however the underlying problem seems to be a neurological disorder, which is undefined. The patient requires a great deal of nursing care and is a behavior problem. At the time of the Board's visit this individual was at Galen, secluded in her room and treatment was directed towards preventing abuse to self or others.

A review of the medical records indicates a desire on the part of the Galen staff to transfer her back to the Warm Springs campus because of a lack of medical problems. These requests were apparently refused. The issue of placement must be resolved.

The staff at both campuses appear to be limited in their capability of providing a program. The program, however, would

require a great deal of one-to-one attention to manage. There is no doubt this individual will require long term treatment.

ADMISSIONS-PLACEMENT [53-21-101(3) and 53-21-142(2) MONTANA CODES ANNOTATED 1985]

The average daily population for the Warm Springs Campus for Fiscal Year 1986 was 301.46 patients, for the Galen campus 172 patients. The administration stated that the population is affected by 1) a decline in the geriatric population (attributed to more home-health and in-community services); 2) procedural standards for admitting involuntary patients and 3) an increase in the number of young chronically mentally ill.

ACCOMPLISHMENTS

17. The hospital administration reports that the referral process between treatment units at the Warm Springs campus has improved. Patients are interviewed by the receiving unit and the placement decision rests with the Clinical Director, Psychiatrist, Director of Treatment Services and the Superintendent.

18. Quarterly meetings, held with Warm Springs staff and representatives from the mental health regions, review admissions and discharges to and from the State hospital. In addition patients anticipating discharge within the quarter are interviewed by mental health center staff.

19. Referrals of developmentally disabled patients at the Warm Springs campus have resulted in the transfer of six patients to Montana Developmental Center. Additional transfers are forthcoming.

20. Admission policies have been updated and distributed to interested agencies. These identify criteria for admission, admissions hours and procedural issues. The Board of Visitors suggest these policies be sent to community hospitals (especially those with psychiatric units) and all county social services offices.

21. Ten residents from the Extended Treatment Unit were placed in a community-based long term care facility. Eight of the ten continue to reside at the community facilities.

DEFICIENCIES

16. During the biennium, waiting lists for Warm Springs patients placement in mental health group homes ranged from ten to twenty per region. Additional group homes are needed to avoid lengthy and costly hospitalization.

17. The referral recommendations from the Montana Youth Treatment Center for patient 49319 did not constitute an appropriate reason for admission. The Youth Treatment staff recommended that the client would "1) benefit from regular community outings with close supervision of staff and 2) work on basic living skills-learn how to keep her bed and perhaps cook a little". These recommendations could be provided in a community

based setting.

18. Private psychiatric facilities need to be made aware of admissions criteria to Montana State Hospital. The presenting problems identified in cases 38337 and 27641 indicate they are appropriate involuntary admissions, not voluntary admissions.

19. The Board of Visitors opposes the admission of youth to Montana State Hospital. Montana law provides that no individual less than eighteen may be voluntarily or involuntarily admitted to the State Hospital.

CONSUMER ISSUES AND PATIENT RIGHTS [53-21-101, 53-21-104,
53-21-142, 53-21-145, 53-21-146, 53-21-147
53-21-148 MONTANA CODES ANNOTATED, 1985]

Since February of 1985 the hospital has had a Patient Grievance Procedure in place. A total of eighty-five grievances have been filed since the procedure was implemented.

The Board of Visitors and their consultants have reviewed the current procedure and recommend the following changes be made:

- 1) Provide patients with the grievance form and envelope addressed to the Patient Grievance Coordinator. This would deter staff "persuasion" to withdraw grievances.
- 2) In emergency situations related to restraint and seclusion, medical treatment, religious worship, personal clothing, visitation and communications decrease the time frame so that the Patient Grievance Coordinator must contact the Unit Supervisor by the next day.

- 3) Make a provision requiring the Unit Supervisor to respond to a complaint in writing within twenty-four hours of receipt. If, at that time, the patient is not satisfied with the results, the patient proceeds to the formal grievance procedures.

ACCOMPLISHMENTS

22. Patient rights information is given to each patient upon admission. In addition patient rights posters were posted on each treatment unit and at the admissions desk. The grievance procedure and patient rights, as documented in state statutes, are identified on this poster.

23. The number of incident reports filed on the Extended Treatment Unit has been significantly reduced. In part, a reorganization of patient wards has helped reduce the incidents of physical assault against patients or staff by fifty per cent.

24. Staff feels positive about the use of the seclusion/restraint committee. The committee meets regularly to review the use of restraints and seclusion on the Warm Springs campus.

25. Patients were observed to be clean and appropriately dressed. Many of the elderly residents at Galen had colorful lap blankets. Special ties adapted to the blankets insured the residents stay warm and covered.

26. Incontinent patients are checked frequently at both the Warm Springs campus (Spratt 219) and the Galen campus. The staff is reluctant to initiate the use of Attends or other diapering

programs. They fear patients may be left too long before checking or changing, with a subsequent increase in skin breakdown.

The Board's consultant observed staff approached these patients with gentle, matter of fact direction and assistance.

DEFICIENCIES

20. The Restraint/Seclusion policy of Montana State Hospital was reviewed by the Board of Visitors and their consultants. There are several consumer, staff development, record keeping issues which need to be refined. These include:

- 1) Provide staff training in restraint/seclusion policies, procedures and techniques. Document attained proficiency in these procedures. In addition provide in-service at least quarterly to assure continued proficiency in the proper techniques and procedures.
- 2) Provide notification for the unit supervisor and physician of all patients who have been placed in restraint/seclusion during their off duty hours (even if the patient is currently not in restraint/seclusion).
- 3) Require that doctors orders for the authorization of restraint/seclusion shall specify the types of behavior for which restraint/seclusion may be used. Protection of self and others is not acceptable.
- 4) Document the less restrictive intervention techniques that must be tried before restraint/seclusion or document why alternatives are inadequate or inappropriate.
- 5) Document that patients have been informed of the reason and justification for restraint/seclusion and what the requirements for release are.
- 6) Patients shall be informed of their right to request an immediate review of restraint/seclusion

- 7) The restraint/seclusion Committee shall meet to review special situations whose review is requested by the patient. The Chairman shall document, within twenty-four hours, agreement or disagreement with the restraint/seclusion and the clinical basis for the decision.

21. The ward furniture at the Warm Springs campus is in poor condition. The majority of the furniture, purchased in 1976, needs to be replaced.

22. There are a number of patients at the Galen campus who have supportive restraints. Because of the number of patients involved, there needs to be a formal, documented review system of the need for such restraints.

23. The Board frequently receives requests about admission procedures, visiting hours, telephone calls, home visits, etc. from parents and family members of residents at Montana State Hospital. In 1973 a pamphlet regarding information for families was published by the hospital, however it has not been updated since. The Board feels this type of information serves a valuable community relations function and provides families with important information.

24. The Patient Bill of Rights and Grievance Procedure should be made available in large print for the elderly and those individuals who have visual impairments.

25. A fenced area near the Geriatric unit of the Warm Springs campus is needed so that patients may spend more time out-of-doors without taxing the minimum staffing. In addition a Hubbard tank or similar whirlpool bath is needed for this unit.

26. The Board's consultant's observed written and verbal

use of the terms "senile aged" and "retards" at the Galen campus. The use of such antiquated, derogative language should not be allowed.

ENVIRONMENTAL [53-21-104(3) AND 53-21-142(13) MONTANA CODES ANNOTATED, 1985]

ACCOMPLISHMENTS

27. The Board's concerns regarding the lack of privacy and deteriorating environmental conditions promise to be alleviated with the new facility, currently under construction. Since the Board's last review the current Forensic Unit has been painted and some of the plumbing has been repaired.

28. Routine maintenance and a rigorous cleaning schedule are evident in the Long Term Care Unit at Warm Springs and the Crockett and Terrill Wards at Galen.

29. A washer and dryer was purchased for the Galen campus. This should help alleviate the problems associated with laundering special items such as sweaters, afghans, etc.

30. The night shift nursing staff at the hospital are to be complimented for their personal efforts of providing seasonal decorations for the wards and for knitting slippers and hats for the residents.

31. At the Warm Springs campus efforts have been made to improve the physical environment of the cafeteria. Ceiling beams have been painted and a floor maintenance schedule has been

implemented.

32. The raw cost per meal, including a limited number of commodities was \$0.89. The Director observed that pre-prepared and pre-proportioned food items, such as sauces, vegetables and meat, have saved time and money.

DEFICIENCIES

27. There is a sixteen inch long tear in the flooring between the dining area and lounge of the day hall in Crockett I. This presents a potential health and safety hazard for the elderly men on this unit.

28. Two of the needed long-range building projects, the energy retrofit plan for the short term unit and insulation for the steam distribution system have short payback periods.

29. Potential safety and fire hazards existed in the kitchen area. The exhausts and hoods were greasy and dirty. Floors, corners, light fixtures and oven tops of the bakery and kitchen were dirty.

30. The bathrooms in the Multi-purpose Building were dirty. Plumbing fixtures need attention and the rooms need to be painted.

31. Additional maintenance, exhaust fans and painting are needed in the shower and bathroom of the Short Term Unit.

RECORD KEEPING [53-21-162 and 53-21-165 MONTANA CODES ANNOTATED,
1985]

The Medical Records Departments at the Warm Springs and Galen campuses have been reorganized and one Registered Records Administrator has been deleted. The administration proposes that one administrator supervises the medical records department at both campuses. The staff, at the time of the Board's visit included five staff at Galen, and seven at Warm Springs. With the reorganization and termination there are currently five staff at Galen and four at Warm Springs.

The Board of Visitors urges the administration to carefully evaluate the status of this reorganization. In addition to one less supervisor, the Warm Springs campus has lost two Green Thumb workers. Issues facing the department and the administration with three less staff include: 1) less time for upgrading and refining record keeping procedures, 2) less supervision, 3) increased time delays in coding, completing discharge analysis and filing.

Statistics provided by the Medical Records Department of each campus indicate the following:

	# of admissions/yr	# of discharges/yr
Galen Campus	1894	1873
Warm Springs Campus	682	722
Totals	2576	2595

ACCOMPLISHMENTS

33. As a result of the Board's last review, a task force was established to review the Medical audit and utilization review process. Changes and additions have been made to the process, including a review of the deficiencies by the Treatment Director and follow-up where appropriate.

34. Case 20763 contained a well detailed treatment plan for a combative patient.

35. A pilot project on the Warren Building, designed to increase accountability has begun. Each contact by staff with a patient is recorded as to date, length of time, and type of contact. This documentation holds promise of tracking staff time, as well as some assurance of quality staff interaction with patients.

The unit supervisor reports an average of thirty hours of activity are provided to the patients on the Warren Building.

36. A careful record of food, fluid intake and bowel habits are kept for the elderly patients. Diet is used as a natural aid for elimination. Difficulties with special diets and preferred diets have apparently been resolved.

DEFICIENCIES

32. A review of medical records further reveals treatment deficiencies inherent in staff shortages. The progress notes document weekly summaries, but the treatment plans are too general. The treatment plans were not tailored to meet specific,

unique problems of the patient. It was difficult to evaluate whether goals were being addressed by treatment methods over time. Treatment methods were weak in charts 49210, 49319, 48863, 47736, 37044, and 36893.

33. Although the diagnostic formulations conducted by the Intake Unit are good, the information does not reach the treatment units in a timely fashion.

34. Weekly medication reviews are not documented as required by law. The current psychiatric shortage has increased this problem.

35. There is a lack of precise documentation of medical problems and subsequent interventions and treatment at both campuses. There seems to be a gap from the time a change in medical status is noted and treatment is initiated in a proper facility. The Board's consultants observed that it is hard to determine exactly what happens because recording is often incomplete.

In case 22617 the patient complained on chest pain. The following day a thorough assessment of the patient symptoms were documented. Eighteen hours elapsed from the first assessment of a significant symptom until the patient was seen by the doctor and transferred to Galen.

In case 2-49336 the individual had been suffering from hypertension prior to admission, but the diagnosis was not made during the initial examination. This problem was not detected until several weeks after admission.

The medical care provided in case 12476 is marginal and raises many questions. Why would an upper gastrointestinal test be ordered on an unresponsive patient with a history of a head injury? Were other diagnostic tests ordered to evaluate this patient? An EEG does not appear to be a pertinent test in this case. The medical notes do not address why the patient has been unresponsive for four days. Was a CAT scan done and if not, why not?

The Board's consultant suggested devising a standardized flow sheet for assessment and documentation of medical problems. In addition documentation of progress and interventions needs to follow.

36. The intricacies of referring patients for medical services seems to negatively affect care. The medical services at Galen seem limited. There is no emergency treatment, no specialty units such as Cardiac Care or neurology. The use of Galen as a midway stop before using community services such as St. James may be a waste of precious time.

The Board urges the administration to thoroughly evaluate the medical care on the geriatric unit and at Galen. Staff from various disciplines expressed concern over the lack of medical coverage, the lack of team participation by the physician and the physicians's ability to accurately assess medical problems in the geriatric patient. In addition the policies that affect transfers of patients to Galen for medical care need to be evaluated. The nursing staff would benefit from inservice to enhance their

assessment skills, to increase the calibre of their recording and a review of the nurse practice act .

37. Documentation of the use of seclusion and restraints in case 4-38119 is professionally unacceptable and in violation of hospital policies and procedures. The problem does not appear to be a lack of written procedures, but the implementation of them. This is another example of critical need for in-service training which allows "on hands" experiences with more trained staff dealing with crises, as well as providing examples of more effective day-to-day therapeutic interventions.

There was no clear supporting information in this case as to why the individual was in full restraints from 6:00 p.m. until 11:15 a.m. the following day. In addition, for this patient, no nursing notes were made from the time the restraints were removed until six days later. One must wonder what went on during this time period, particularly given the fact that there is serious question as to the appropriate treatment of this patient by staff.

38. The Board's consultants noted that several treatment plans were undated or in many cases that treatment plan was written in ink and the date of the plan was erased and updated in pencil. This practice does not comply with the intent of the law. The Board noted that a medical problem occurred regarding extrapyramidal symptoms. The treatment plan stated "none noted so far". That observation was undated, so the doctor, nurse or

survey team does not know for how long the extrapyramidal reactions were not observed.

In addition when changes are made in the treatment, they are to become part of the treatment plan. These changes were not routinely charted. See records 47208, 37938, 47590, 46670, 38119, 30031, and 36864.

39. The random record review at the Galen campus indicated no updated psychological reports or social histories have been done since 1981. There was no record of limited guardianship for the patients, many of whom are medically fragile. See records 21944, 21802, 38047, and 12010. (Guardianship was documented for the residents who had guardians.)

MEDICATION [53-21-142 and 53-21-145 MONTANA CODES ANNOTATED,1985]

ACCOMPLISHMENTS

37. Unit 86 of the Forensic Unit developed a form for recording unsuccessful antipsychotic medication trials. The Board's consultants recommend that such a form be used throughout the institution. The form needs to include the date, the medication and the reason for discontinuation (ineffective, side effects, etc.) The form should be kept in the medical record for use when patients are re-admitted or transferred between treatment units.

38. Despite the shortage of psychiatrists the Board's consultants observed that they tend to write informative notes

when they see patients. The progress notes on the Galen campus are as frequent as the clinical conference notes. The notes, however are less informative and do not explain medication changes or additions.

DEFICIENCIES

40. The majority of reviewed records contained no medication history. It is widely held that the basis for determining the best psychotropic medication for an individual is that individual's personal history of psychotropic medication use and response. In addition the history should include information regarding allergies, drug abuse, etc. The Board's consultants observed that records of more recent admissions to the Warm Springs campus had more complete information. The Galen campus did not record any medication history.

It would be extremely useful for the new psychiatrists to know which antipsychotic a patient has received throughout their psychiatric history and how they have responded. A continuous record of medications used is not available. A form should be developed or incorporated into the medical history which would list all medications received, indications and target symptoms, dosage, route, response, allergies and side effects. Such a summary of medication use would allow more rational prescribing and more safe and effective therapy.

41. There were many drugs for medical conditions which did not have a clear indication. See the Medication Appendix and

charts 28152, 20763, 20063, 37780, 31729, 46682, 22935, 13798, 37661, 32238, and 45917.

In cases 28152, 20763, 34059, 31729, and 37661 psychotropic medications were used without a well defined indication. In another case, 34059, a change was made without an explanatory note.

42. In none of the cases reviewed was there documentation that the psychiatrists were reviewing medications weekly, as required by the Mental Commitment and Treatment Act. In fact, the Board's consultants noted that the review of medications use does not have a regular schedule. This results in medications continued longer than probably needed or dosages not adjusted as frequently as they should be.

The annual physical examination required is absent in case 49375, significantly overdue in case 37760 and not dated in 45917.

43. On the Galen campus there is a long term case of osteomyelitis which should no longer happen. This case, 13798, must be referred to intensive therapy. The use of Nafcillin to suppress the infection in the bone is rarely used orally, as it is poorly and erratically absorbed from the GI tract. Moreover, the infection has been present a long time. The infected hip should receive intensive antibiotic therapy to induce a cure. An infectious disease and orthopedic consult are long overdue.

44. The use of anticholinergic agents (drugs used to suppress adverse effects from the antipsychotic agents) appears

to be continued longer than needed. This reflects either poor consideration of side effects, lack of frequency of attention, or conscious decisions to continue these agents without an apparent indication. See records 28152, 20763, 37760, 34513, 22935, 13798, 38257, 27667, 36893, 34822, 37044, 37346.

The adverse effects do not always occur and may not reoccur when anticholinergic agents are discontinued. The Board's consultants suggest that the pharmacist and the nursing staff develop a check-off flow sheet to document the type of extrapyramidal effects including dystonia, akathisia, stiffness and tremors.

A program for revaluation of the need for anticholinergic agents would be to treat the patient for three months after occurrence, withdraw and then treat six months if there is a reoccurrence, and evaluate at least yearly.

Patients 37392, 49208, 37732, 34681, 36020, 36744 are receiving anticholinergic agents on a continuous basis despite receiving an antipsychotic agents which is typically not associated with causing the adverse effects. The anticholinergic agents should be discontinued and the need reevaluated.

In one case, 41968, the patient continues to receive the anticholinergic agent despite discontinuation of the antipsychotic agent.

45. In three cases, 28152, 37780, and 34059 a seizure disorder represents a contraindication to medication. However since there is no seizure recorded it is difficult to determine

if problems have occurred, if the anticonvulsant is working or if the medication should be stopped. A seizure record needs to be instituted immediately. In case 46682 the dosage should be clearly be increased to bring the seizures under control. In cases 28152 and 25190 the seizure history is unclear and needs to be reassessed. In addition in cases 46682, 37780, and 25190, where multiple anticonvulsants are in use, there is a potential for problems when one of the drugs is changed.

The physicians questioned the need for an anticonvulsant in case 28152, but nothing has been done. The Board's consultant noted that the agents prescribed are consistent with the diagnosis of grand mal epilepsy. There is, however, no documentation for the need of two drugs. In addition the problem with the phenytoin is the use of the suspension. It is necessary, because the suspension is very thick, to shake the bottle vigorously for a full five minutes before each use. It is highly unlikely that this is being done routinely. If the drug is not resuspended adequately the patient could be receiving an improper dosage.

46. In seventeen of the reviewed cases, a medication which could be administered once daily was given several times during the day. Most of these involve antipsychotic agents. There are some occasions when dividing them is appropriate, but this is not indicated. If given once daily, the cost of the drug would likely be less and staff time (pharmacist and nurse) would be saved.

47. Although serum drug concentrations are monitored episodically, this should be done on a more routine basis. When blood is drawn for drug levels, the time of the draw should be recorded as this is the important information for interpreting the results.

48. Adverse drug reactions to psychotropic agents were documented in cases 20063, 37880, 49375, 13656, 36752, 46682, 37661. Adverse reactions were present, but not adequately documented or evaluated in cases, 38507, 34822, 37044, 34681, and 36744. This low incidence of side effects suggests poor documentation, inadequate review and/or lack of active treatment.

49. The pharmacists are labeling the unit dose medications with brandnames, even though the drug is actually a generic. They are aware that this is illegal, but feel compelled to do so to eliminate confusion on the part of the nurses. These medications are also being charted on the medication administration record as brandname, even though a generic was administered.

SUMMARY

"Modern somatic therapy, for convenience, may be said to have begun in the early 20th century, it is helpful to have some idea as to the state of the mentally ill at that time. Patients with psychosis of any type were invariably hospitalized for long periods of time whether they were rich or poor, but more especially the latter. They were seldom discharged before three months, and those not discharged by six months had a poor prognosis for being discharged within two years. Outpatient clinics were to a large extent nonexistent. State hospitals built far away from residential areas, were difficult for relatives to visit, an in structure, resembled prisons. Such hospitals, took care of the acute and chronically mentally ill, were grossly overcrowded with large dormitory wards of fifty beds and upward, and provided absolutely no privacy. A nurse and three or four attendants for the day shift might look after such a ward, with one psychiatrist for, in some cases, every 200 to 300 patients. Occupational and recreational therapies, if such existed, were centralized, but in fact, were not available for the majority of patients."

This paragraph from Kaplan's class Comprehensive Textbook of Psychiatry describing mental health treatment in the early twentieth century unfortunately contains similarities to Montana State Hospital in 1986-1987.

The essence of the right to treatment is the guarantee that services will be individualized to the needs of the patients. When there are inadequate numbers of staff, this need is not being met. Without staff which is adequate in training, numbers and compassion, the State's liability increases. The Board recognizes that the current staff at Montana State Hospital is working hard, with the limited resources that are available, but we must assure the rights guaranteed by the Mental Commitment and Treatment Act are not compromised.

It seems clear, in understanding the historical funding track record of Montana State Hospital, the chronic understaffing problems, and the difficulty in attracting higher paid professional staff, that new dollars are slim, therefore improvements will have to be made within the existing structure and administration. The challenge for administration and staff is to work cooperatively, communicate within all levels of the management system and strive for better patient treatment.

FOOTNOTES

1

Conducting this review were Board members: Allen V. Bertelsen, Joe DeLong, Virginia Kenyon, L.P. Noonan, and Gracia Schall; staff member, Kelly Moorse and in-state consultants: Robert Bateen, Clinical Psychologist; William Docktor, Clinical Pharmacist; Dianne Gitlin, Nursing Specialist in Gerontology; Michael Rivey, Clinical Pharmacist; Frank Seitz, Clinical Psychologist; and Marrianne Spitzform, Clinical Psychologist.

2

The purpose of this evaluation was to review the services of Montana State Hospital according to the standards set forth in Title 53, Chapter 21 of the Montana Codes. the file review and patient and staff interviews were designed to preserve confidentiality.

APPENDIX A
MEDICATION

Number: 49208
Admission: 8/11/86
Site: Unit C
Birthdate: 11/24/62

Diagnosis: Schizophrenia, chronic
paranoid
Medication: Loxapine (Loxitane)
Benztropine (Cogentin)
Carbamazepine (Tegretol)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in appropriate locations in the medical chart.
3. Drug Abuse: Documented in summary from another institution which is present in the chart; not documented at this institution.

CURRENT MEDICATIONS

1. Indications: Loxapine is an antipsychotic and carbamazepine is an antimanic agent which are used to control the symptoms of the patient's schizophrenia. The loxapine is being used following adverse effects associated with haloperidol and fluphenazine trials (see below). Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents. The patient is receiving the anticholinergic agent presently on a continuous basis and extrapyramidal symptoms are subsiding since initiation of loxapine therapy. The need for continued anticholinergic agent should be reassessed when appropriate since loxapine is less associated with extrapyramidal reactions than other antipsychotics.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Extrapyramidal adverse effects are clearly documented in association with haloperidol therapy in this patient; the further use of the agent should be avoided if possible and a note made to that effect in the patient history (dystonia was mentioned in admit note but was not associated with a causative agent, presumably haloperidol).
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: No physical exam (refused on admit) or recent mental status report is present. Physician progress notes and medication review are written at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present since 8/86.

TEGRATION: Not documented.

Diagnosis: Schizophrenia, chronic

undifferentiated 295.92

Site: Warren 41

Birthdate: 6/17/43

Medication: Mesoridazine

(Serentil)

Trihexyphenidyl

(Artane)

Multivitamin

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented to fluphenazine in all appropriate locations in the medical chart.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Mesoridazine is an antipsychotic agent used to control the symptoms of schizophrenia. Trihexyphenidyl is an anticholinergic agent which suppresses extrapyramidal reactions often associated with antipsychotic agents. Mention of such adverse effects is made in notes only once in early July 86 without description. The need for the anticholinergic agent on a continuous basis should be reassessed; mesoridazine is an antipsychotic that is associated with a low incidence of extrapyramidal adverse effects. The multivitamin is being used as a nutritional supplement although its need is not documented.
2. Contraindications: None documented, but poor compliance with medication is noted.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Extrapyramidal adverse reaction was reported by the patient in early July which would probably be attributed to the antipsychotic agent.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 6/13/86. The most recent mental status report was dated 6/26/86. Physician progress notes and medication review are written at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present since 6/86.

INTEGRATION: Not documented.

Number: 12039
Admission: 2/3/55
Site: Spratt 215
Birthdate: 3/14/15

Diagnosis: Schizophrenia, chronic
undifferentiated 295.90
Mental retardation,
borderline 317.
Urinary tract infection,
recurrent
Neurogenic bladder
COPD, mild emphysema
early cataracts
S/P diverticulosis
S/P cystocele/rectocele repair
S/P corigation for cervix
cancer

Medication: Phenazopyridine (Pyridium)
Theophylline (SloBid)
Sustacal

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Patient has allergies to several antimicrobial agents (Bactrim, Ampicillin, Macroclantin). However, there is no consistency between allergy locations in the chart, e.g. Macroclantin allergy does not appear on the medication administration record and none are present on the physician orders. Also, the type of adverse reactions are not specified, e.g. does ampicillin cause a rash or just upset the patient's stomach (if stomach, therapy with amoxicillin is still viable in the patient).
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Antipsychotic agents have recently (9/86) been discontinued in this patient and the patient appears to be doing well. Phenazopyridine is an urinary analgesic/antiseptic agent which lessens the symptoms of dysuria, urgency, and frequency associated with lower urinary tract disorder. She has received multiple courses of antimicrobial agents for recurrent urinary tract infections, typically caused by E. coli. The frequency of recurrence suggests prophylaxis with Bactrim (? is this patient allergic), trimethoprim alone (one step resistance is of concern), or methenamine with urinary acidification with ascorbic acid 1gm four times daily should be considered. The latter method with methenamine + ascorbic acid or ascorbic acid alone is preferable since there is less risk of the emergence of resistant organisms. If antimicrobials are used, low dose regimens (Bactrim- 1 tablet 3 times weekly) should be used. If infections are in association with catheterization, antimicrobials could be used in conjunction with such procedures. Catheterization should be minimized in this patient and antibiotic treatment should be avoided in

The absence of white blood cells in the urine. Theophylline is a bronchodilator which is beneficial in COPD and this patient has some documented benefit from bronchodilators. Sustacal is a nutritional supplement.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: The patient suffered urinary retention when treated with benztropine and tremors and drooling in association with fluphenazine therapy; neither are presently prescribed. The patient's urinary difficulty could in some part be attributed to theophylline which has a mild diuretic action, but any contribution would be difficult to elucidate in this complicated urinary picture.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 1/13/86. The most recent mental status report was dated 11/5/85. Physician progress notes and medication review are performed at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 37346
Admission: 1/24/86
Site: Spratt 215
Birthdate: 6/27/16

Diagnosis: Chronic psychosis with schizo-
phrenia-like behavior
S/P viral encephalitis
S/P temporal lobe surgery for
viral abscess
S/P sigmoid resection 1/86
S/P colostomy 2/86
Hx diverticulitis
S/P hysterectomy & rectocele
repair

Medication: Perphenazine (Trilafon)
Benztropine (Cogentin)
Chlorazepate (Tranxene)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Multiple allergies are documented on the front of the medical chart, but are not documented on physician order sheets.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Perphenazine is an antipsychotic agent which controls psychotic symptoms. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic use. No such adverse effects are documented in the patient who is receiving the anticholinergic agent on a continuous basis at a moderately high dose. The use of continuous anticholinergic agent should be assessed in this patient since anticholinergic-induced psychosis would be difficult to detect in this confused patient. Chlorazepate is a long-acting benzodiazepine agent presumably being used for anxiety symptoms associated with this patient's psychosis. The elimination of long-acting agents is further lengthened in elderly patients which could contribute to confusion; the use of agents without active metabolites such as oxazepam or lorazepam should be considered.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: The patient underwent a sigmoid resection resulting from fecal impaction which could have been attributable in part to an anticholinergic effect from benztropine. The patient's confusion could be contributed to by use of chlorazepate, and possibly benztropine, in moderately high doses.
5. Dosage: All dosages appear to be within acceptable limits.

5. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 11/29/85. The most recent treatment plan review was dated 4/3/86. Physician progress notes and medication review are performed at least monthly. No mental status exam was available.

3. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86

INTEGRATION: Not documented. Enewpage

Number: 47992

Admission: 6/5/85

Site: Spratt 215

Birthdate: 2/11/17

Diagnosis: Huntington's chorea, unusual
presentation
other suspected mental
disorder
S/P decubitis, buttock &
scrotum

Medication: Haloperidol (Haldol)
Benztropine (Cogentin)
Fluphenazine (Prolixin)
Ensure

HISTORY

1. Medication: Documented on the medical history, but no details are provided.

2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in appropriate locations in the chart.

3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Haloperidol and fluphenazine are antipsychotic agents which help the chorea associated with Huntington's disease. The fluphenazine is being used on an as needed basis. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic; it is prescribed on an as needed basis in this patient. Ensure is a nutritional supplement.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: A dose of haloperidol was held due to hypotension which is a common adverse effect of the agent. An increase in sedation was associated with an increase in haloperidol dose. Previously, an increase in the movement disorder was associated with another

antipsychotic agent, fluphenazine. The patient has been incontinent of feces which could in some part be contributed to by the Ensure supplement.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 6/17/86. The most recent mental status report was dated 8/9/85. The treatment plan review was dated 4/17/86. Physician progress notes and medication review are performed at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86.

INTEGRATION: Not documented.

Number: 49168
Admission: 7/25/86
Site: Spratt 215
Birthdate: 3/27/07

Diagnosis: Alzheimer's disease 331.0
Senile dementia 290.0
Hx: ASHD with sinus
tachycardia
aortic stenosis
increased fasting blood
sugar
hyperlipemia
urinary tract infection

Medication: L-tryptophan
Diphenhydramine (Benadryl)
Milk of Magnesia with Cascara
Docusate with casantranol
(Doxidan)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in appropriate locations on the medical chart.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: The L-tryptophan is a precursor to the formation of serotonin, a neurotransmitter in the central nervous system. It appears the agent is intended for use in the dementia from Alzheimer's disease, although this consultant is not aware of present research substantiating such a benefit. The agent does have a sedating pharmacological effect on the patient. Therefore, a well evaluated trial of the agent would be justifiable. Diphenhydramine is an antihistamine agent with anticholinergic potency which was being used as needed for extrapyramidal adverse effects associated with prior antipsychotic therapy with haloperidol; the order should be discontinued. Docusate with casantranol is a stool softener with a mild stimulant action.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Haloperidol therapy was discontinued in this patient who appeared to be unsteady and lethargic while receiving the medication.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 10/3/86. The most recent mental status

report was dated 7/31/86. Physician progress notes and medication review are performed at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86.

INTEGRATION: Not documented.

Number: 34681

Admission: 1/22/85

Site: Warren 43

Birthdate: 2/21/60

Diagnosis: Schizophrenia, chronic

undifferentiated 295.92

Mental retardation, moderate

318.0

Mixed drug/alcohol abuse

305.90

Medication: Chlorpromazine (Thorazine)

Benztropine (Cogentin)

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented in the medical chart in appropriate locations.
3. Drug Abuse: Not documented; however, data is available in prior hospitalization records contained in the medical chart.

CURRENT MEDICATIONS

1. Indications: Chlorpromazine is an antipsychotic agent which controls the symptoms of schizophrenia. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with the use of antipsychotic agents. There is no documentation of such adverse effects despite the continuous administration of the anticholinergic agent and chlorpromazine typically does not cause such anticholinergic effects; the continued need for the agent should be evaluated. It is also noted that a significant deterioration in the psychiatric status has occurred, raising the concern that the dose of antipsychotic may be excessive in this patient.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: The patient was noted to be drinking large amounts of water in August and has complained of the need for glasses in October. Both of these effects (dry mouth & blurred vision) could be adverse effects of the continuous use of moderate doses of the benztropine.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 1/28/85. The most recent mental status report was dated 10/8/86. Physician progress notes and medication review are performed at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86

INTEGRATION: Not documented.

Number: 46746
Admission: 1/16/86
Site: Warren 43
Birthdate: 11/7/57

Diagnosis: Schizophrenia, chronic
undifferentiated 295.92
Acne
Epidermophytosis pedis
Premenstrual syndrome

Medication: Trifluoperazine (Stelazine)
Benztropine (Cogentin)
Acetaminophen
Clotrimazole cream (Lotrimin)

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented in the medical chart in all appropriate locations.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Trifluoperazine is an antipsychotic agent which controls the symptoms of schizophrenia. It was used following an unsuccessful trial with thioridazine despite previous success with trifluoperazine. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents; it is being used continuously despite a lack of documentation of such adverse effects. The acetaminophen is an analgesic effective in the treatment of pain such as occurs in dysmenorrhea. Clotrimazole is an antifungal agent which is being used topically in treating the fungal infection of the feet.
2. Contraindications: None documented, but poor compliance with medication has been a problem. Therefore, the need for all agents (i.e. benztropine) should be assessed.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 4/2/86. The most recent mental status report was dated 1/27/86. Physician progress notes and medication review are performed at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.

10. Medication Record: Present since 5/86.

INTEGRATION: Not documented.

Number: 38011 Diagnosis: Bipolar affective disorder
Admission: 8/29/86 (4th admit) 296.4
Site: Warren 42 Alcohol dependence, episodic
Birthdate: 3/10/41 303.92
Medication: Lithium carbonate
Perphenazine (Trilafon)
Benztropine (Cogentin)

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in all appropriate locations in the medical chart.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Lithium carbonate is an antimanic agent which decreases the recurrence of manic attacks. Perphenazine is an antipsychotic agent which is being used to treat psychotic symptoms associated with the mania in this patient. While antipsychotics are typically needed only during acute manic attacks, it is noted that the patient has psychotic symptoms and that schizoaffective disorder has been previously diagnosed; it appears that continuous antipsychotic treatment is justified. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects which often occur with antipsychotic agents and the agent is being appropriately used on an as needed basis.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 8/29/86. The most recent mental status report was dated 9/3/86. Serum lithium concentrations are being monitored monthly and are within normal range. Physician progress notes and medication review are performed at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present since 8/86.

INTEGRATION: Not documented.

Number: 36020
Admission: 3/7/86
Site: Warren 42
Birthdate: 10/1/53

Diagnosis: Schizophrenia, chronic
undifferentiated 295.92

Medication: Mesoridazine (Serentil)
Trihexyphenidyl (Artane)

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergy to aspirin is documented in all appropriate locations within the chart and on the treatment plan.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Mesoridazine is an antipsychotic agent which is indicated for the treatment of the symptoms of schizophrenia. The patient returned to Warm Springs after decompensation in the community setting which appeared to be associated with dosage reduction of the same antipsychotic agent. After readmit, the patient was tried on numerous antipsychotic agents, including haloperidol, fluphenazine, and thiothixene, before resuming mesoridazine. In consideration of the previous benefit from the mesoridazine, the trials of other antipsychotics agent seem unjustified. Trihexyphenidyl is an anticholinergic agent which suppresses the extrapyramidal adverse effects often seen with antipsychotic agents; the agent is being used on a continuous basis in this patient. No extrapyramidal effects are noted and mesoridazine is an antipsychotic which is unlikely to cause such effects; the need for continuous trihexyphenidyl should be reassessed.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: The patient has been treated for constipation from June to September which is probably associated with the anticholinergic agent, trihexyphenidyl. No problems have been noted since the dose was lowered from three times daily to once daily.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 3/7/86. The most recent mental status report was dated 3/27/86. Physician progress notes and medication review are performed at least monthly. It was noted that the treatment plan was NOT current with the present medication regimen.
8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 38063
Admission: 12/6/85
Site: Unit 56
Birthdate: 10/23/53

Diagnosis: Schizophrenia, paranoid,
chronic 295.32
Hx: alcohol abuse 305.00
mixed drug abuse 305.90

Medication: Trifluoperazine (Stelazine)
Trihexyphenidyl (Artane)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in appropriate locations in the medical chart; no mention is made of past adverse effects.
3. Drug Abuse: Documented on the medical history as extensive, but no details are provided.

CURRENT MEDICATIONS

1. Indications: Trifluoperazine is an antipsychotic agent which is indicated in the treatment of the symptoms of schizophrenia. The agent does not appear to be having significant benefit in this patient. An unexplained trial of 3 days duration of haloperidol was tried in August, apparently without benefit. Trihexyphenidyl is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents; it is being used on a continuous basis. The agent was used after trials with other anticholinergic agents; the reason for change of agents is not documented. Also, see Dosage section below.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Noticable body tremors are documented in Sept. and are likely extrapyramidal adverse effects from the antipsychotic agent.
5. Dosage: All dosages are quite high in this patient. The dose of trifluoperazine in consideration of patient status suggests this agent is not rendering significant benefit, and that another antipsychotic agent should be attempted. The dose of the anticholinergic agent also is above normal; any psychotic adverse effects of the anticholinergic agent would be difficult to detect in this patient. Lowering of the anticholinergic dose should be attempted, with anticholinergic coverage on an as needed basis. The use of an antipsychotic agent not likely to cause extrapyramidal effects, such as chlorpromazine or thioridazine, may be attempted.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 12/6/85. The most recent mental status report was dated 8/15/85. Physician progress notes and medication review are performed at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86.

INTEGRATION: Not documented.

Number: 37517
Admission: 7/31/85
Site: Unit 86
Birthdate: 5/30/56

Diagnosis: Schizophrenia, chronic
undifferentiated 295.70
Obesity
Error of refraction
Tremor, probable
extrapyramidal
S/P suicide attempt with
lithium

Medication: Thiothixene (Navane)
Diphenhydramine (Benadryl)
Lithium carbonate
Psyllium (Metamucil)
Benztropine (Cogentin)
Simethicone (Mylicon)
Cannonballs
Aspirin
Acetaminophen

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Thiothixene is an antipsychotic agent and lithium is an antimanic agent which are used in the treatment of the symptoms of schizophrenia. Diphenhydramine is an antihistamine agent with high anticholinergic potency and benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents. The diphenhydramine is being used on a scheduled basis while the benztropine is used as needed; the orders for both medications is not justified. Simethicone is an antiflactulant for the treatment of abdominal gas and psyllium and cannonballs are laxative products for the treatment of constipation. Aspirin and acetaminophen are analgesics being used as needed for the treatment of pain.
2. Contraindications: No absolute contraindications, although the suicide attempt with a medication in the current regimen, lithium, is noted.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: A tremor is a problem which could be either extrapyramidal effects from the antipsychotic agent or a lithium-induced tremor; there is no description of the tremor

(coarse vs. fine). Anticholinergic agents would not be expected to affect lithium tremor. The patient obviously has problems with constipation since she is receiving 2 laxative medications; this could represent an anticholinergic adverse effect.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 6/13/86. The most recent mental status report was dated 9/4/86. Physician progress notes and medication review are performed at least monthly. Serum lithium concentrations are monitored monthly; these could be monitored every 3 months if desired since levels are fairly stable in this patient.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 36744
Admission: 5/15/80
Site: Unit 56
Birthdate: 3/20/53

Diagnosis: Schizophrenia, paranoid 295.32
Depression
Hx: suicide attempts

Medication: Chlorpromazine (Thorazine)
Trihexyphenidyl (Artane)
Multivitamin

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented to Mellaril and aspirin in all appropriate locations; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Chlorpromazine is an antipsychotic agent which is used in the treatment of the symptoms of schizophrenia; it has been used only a short period of time after what appears to be unsuccessful therapy with trifluoperazine. Trihexyphenidyl is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents. Such effects have not been noted in this patient and chlorpromazine is very unlikely to cause such effects; it appears this medication should be discontinued. The patient is poorly compliant and often refuses medication; the discontinuation of the anticholinergic agent should be viewed by the patient as a positive action by the medical staff.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented, including extrapyramidal adverse effects.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 6/2/86. The most recent mental status report was dated 2/14/86. Physician progress notes and medication review are performed at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 46682
Admission: 9/15/86
Site: Crockett III
Birthdate: 12/16/51

Diagnosis: Dementia secondary to
 unspecified type of CNS
 degenerative disease
 Seizure disorder, grand mal
 Tardive dyskinesia
Medications: Phenytoin (Dilantin)
 Valproic acid (Depakene)
 Lorazepam (Ativan)
 Bisacodyl suppositories
 (Dulcolax)
 Diazepam (Valium)

HISTORY

1. Medication: The admission note list current medications; but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented on the transfer form: no mention is made of past adverse drug reactions.
3. Drug Abuse: not documented.

CURRENT MEDICATIONS

1. Indications: Phenytoin and valproic acid are anticonvulsant agent used to suppress seizure activity.

Lorazepam is an antianxiety agent which was used to help control aggressive, combative and self-abusive behavior. On 10/16/86 diazepam was substituted hoping a longer acting agent would be more effective.

Bisacodyl suppositories were used as needed presumably for constipation.

2. Contraindications: None documented.
3. Drug Interactions: Phenytoin and valproic acid affect the elimination of one another and the dosages of one or both may needed to be adjusted.
4. Adverse Drug Reactions: On 10/17/86 there was a mention of drowsiness and on 10/21/86 slurred speech. These are probably secondary to diazepam. Since this regimen appears to have helped it is seasonable to continue at the same dosage to see if tolerance develops. If not, it will be necessary to reduce the dosage of diazepam.
5. Dosage: All dosages appear to be within acceptable limits. The serum valproic acid concentration was slightly below the usual therapeutic range on 9/30/86 and the dosage was increased on 10/9/86. The phenytoin concentration was somewhat low on 10/6/86 and the dosage should be increased given the seizure activity around this time period. The phenytoin and diazepam could probably be given once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 9/15/86. Physician progress notes have been written frequently. The underlying disease process has defied definition and therapy has been strictly symptomatic. It appears some progress has been made in controlling behavior recently but it remains if significant control can be maintained without undue sedation. The seizure disorder could be better controlled.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: The underlying problem seems to be a neurological disorder which is undefined. The patient needs lots of nursing care and is a behavior problem. She does not appear to be appropriate for Crockett III nor for any ward at Warm Springs.

Number: 25190
Admission: 6/26/78
Site: Warren 41
Birthdate: 2/12/39

Diagnosis: Organic personality disorder
Grand mal epilepsy
Exogenous obesity
Dorsal kyphosis
Medications: Phenytoin (Dilantin)
Phenobarbital
Valproic acid (Depakene)

HISTORY

1. Medication: Documented on the medical history, but no details are provided.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Phenytoin, phenobarbital and valproic acid are all anticonvulsants used to suppress the seizure disorder. There is insufficient information in the ward record to determine if all three agents are needed.
 2. Contraindications: None documented.
 3. Drug Interactions: All three anticonvulsants affect the elimination of one another. Any change in dosage of one may result in a need for a dosage adjustment of the others.
 4. Adverse Drug Reactions: None documented.
 5. Dosage: All dosages appear to be within acceptable limits. The phenytoin could be given once daily. Serum concentrations of phenobarbital and phenytoin have generally been within the therapeutic range. Valproic acid concentrations have been slightly below therapeutic range.
 6. Prescriber: Clearly identified.
 7. Review: The most recent physical exam was dated 6/12/86. The most recent psychological report was dated 8/7/86. The social history update was dated 10/2/86. There is no seizure record. Psychiatrist progress notes have been at long intervals (4/28/86, 9/2/86).
 8. Goals: Specific goals of drug therapy are not documented.
 9. Patient Education: Inappropriate.
 10. Medication Record: Present.
- INTEGRATION: Not documented.

Number: 46697
Admission: 6/25/86
Site: Crockett I
Birthdate: 12/20/37

Diagnosis: Dementia associated with
Huntington's chorea
Chronic right olecranon
bursitis
Tremor, ?EPS
Drooling

Medications: Dietary supplement (Sustacal)
Haloperidol (Haldol)
Benztropine (Cogentin)
Diazepam (Valium)
Bacitracin ointment
Vitamin A & D ointment
(A and D)
Bisacodyl suppositories
(Dulcolax)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: There is no documented indication for dietary supplements.
Haloperidol is an antipsychotic agent used in this case to control combative aggressive behavior.
Diazepam is an antianxiety agent also used for behavior control. Their effectiveness is not well documented.
Benztropine is an anticholinergic agent used to control drooling and to treat extrapyramidal side effects from the haloperidol.
Bacitracin ointment was used to treat open sores; vitamin A & D ointment for urine burns. These sores and burns should not be occurring regularly.
Bisacodyl suppositories were used as needed presumably for constipation.
2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: The tremor is suspected of being at least in part an extrapyramidal side effect from haloperidol. It was appropriately treated with benztropine.
5. Dosage: All dosages appear to be within acceptable limits. The haloperidol could be given once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 7/29/86. There are two clinical conferences (6/25/86 and 7/30/86). Physician progress notes have been written at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 22935
Admission: 1/15/80
Site: Crockett I
Birthdate: 7/27/13

Diagnosis: Mental Retardation
Chronic constipation
Schizophrenic reaction
History of hiatal hernia
Intermittent fever of
uncertain etiology
responding to antibiotics

Medications: Mesoridazine (Serentil)
Dietary supplement (Sustacal)
Terbutaline (Brethine)
Danthron and docusate sodium
(Doxidan)
Multiple vitamins with
minerals
Benztropine (Cogentin)
Cimetidine (Tagamet)
Aluminum and magnesium
hydroxide with simethicone
(Mylanta)
Trimethoprim and sulfmethox-
azole (Septra DS)
Cephalexin (Keflex)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Mesoridazine is an antipsychotic agent probably used to suppress some of the manifestations of schizophrenia. Benztropine is an anticholinergic agent used to prevent the extrapyramidal side effects of the mesoridazine. Usually it is not necessary to continue this agent long term but in this case the tremor persists.

There is no documented need for either dietary supplements or multiple vitamins with minerals.

Terbutaline is a bronchodilator. There is no documented need for it nor is there a history of any breathing difficulty.

Danthrone is a stimulant laxative; docusate sodium is a stool softener. These are used in the management of chronic constipation.

Cimetidine inhibits acid secretion in the stomach. Aluminum and magnesium hydroxide neutralizes

acid. These agents were used to prevent problems associated with hiatal hernia.

Trimethoprim and sulfamethoxazole and cephalexin are anti-infective agents used to treat urinary tract infections. The latter is an unusual agent for this use, but these infections have been recurrent which often leads to the use of several different antibiotics.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits. The antipsychotic could have been administered once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 6/25/86. Physician progress notes and clinical conference notes have been written frequently but do not explain most medication changes. For example, the dosage increase of mesoridazine on 8/21/86 is not accompanied by an explanatory progress note.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 13798
Admission: 1/28/80
Site: Terril III
Birthdate: 6/30/15

Diagnosis: Cerebral arteriosclerosis
Paranoid schizophrenia
Diabetes mellitus, type II,
diet controlled
Osteomyelitis of proximal
left femur
Status post left hip fracture
with prosthesis
Decubitus ulcer right buttock
Exogenous obesity

Medications: Nafcillin
Terbutaline (Brethine)
Benztropine (Cogentin)
Diphenhydramine (Benadryl)
Docusate calcium (Surfak)
Psyllium (Vegetable laxative)
Chlorpromazine (Thorazine)
Docusate sodium syrup
Trimethoprim and sulfamethoxazole (Septra DS)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Not documented.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Nafcillin is an antibiotic used to suppress the osteomyelitis-- an infection in the bone. This agent is rarely used orally as it is poorly and erratically absorbed from the GI tract. In addition this infection has been present for a long time and this agent used continuously. This is not acceptable. This infected hip should receive intensive antibiotic therapy to induce a cure. This cure will likely involve replacement of the prosthesis. An infectious disease and orthopedic consult are long overdue.

Terbutaline is a bronchodilator. There is no indication for its use documented.

Docusate calcium, docusate sodium, and psyllium are all used to manage constipation. The docusate sodium was substituted for the calcium on 9/24/86.

Benztropine is an anticholinergic agent. There is no specific documentation of its need but it is most commonly used to treat or prevent extrapyramidal side effects from antipsychotics.

Chlorpromazine is the only antipsychotic currently in use and it is one which is less likely to cause these types of side effects. In addition, it is not necessary to continue the anticholinergic agent

forever. Usually after a few months of stable dosage the anticholinergic can be tapered and discontinued without return of the side effects.

Diphenhydramine is an antihistamine. Its use is not documented. It was given at bedtime daily suggesting it may have been used to help sleep. One common side effect is sedation.

Chlorpromazine is an antipsychotic agent used to suppress some of the manifestations of schizophrenia and, more specifically, to help control bizarre behavior.

Trimethoprim and sulfamethoxazole is an anti-infective used to treat a urinary tract infection.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits. The chlorpromazine could have been administered once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 9/25/85 and is almost a month overdue. Physician progress notes and clinical conference notes have been written frequently. The osteomyelitis and draining sinus need attention (see indications).

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 37661
Admission: 9/26/79
Site: Minimum 85
Birthdate: 5/21/59

Diagnosis: Mild mental retardation with
poor impulse control
Schizophrenia, latent
Acne

Medications: Tretinoin Gel (Retin-A)
Tetracycline
Soap (Neutragena)
Clonidine (Catapres)
Mesoridazine (Serentil)
Benztropine (Cogentin)
Dietary supplement (Sustacal)
Thiothixine (Navane)
Trihexyphenidyl (Artane)

HISTORY

1. Medication: Not documented.
1. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
1. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Tretinoin gel, tetracycline and soap are all used to control acne. The type is not documented.

Mesoridazine and thiothixine are both antipsychotics. The mesoridazine was stopped on 6/9/86 and the thiothixine was begun on 6/13. This was apparently done because of several months of gradual deterioration. The thiothixine did not control the symptoms as well and was switched back to mesoridazine on 6/15/86. The exact symptoms are not described but probably related to some type of aggressive symptoms as the individual was transferred to a security unit. The term latent schizophrenia usually refers to schizoid personality disorder and would not require antipsychotic therapy.

Benztropine and trihexyphenidyl are anticholinergic agents used to treat and suppress extrapyramidal side effect from the antipsychotics. Benztropine was discontinued at the same time as mesoridazine on 6/9/86. Trihexyphenidyl was started on 6/15/86 when mesoridazine was reinstituted. Akathisia continues despite continued treatment.

Clonidine is an agent which was apparently used to help control behavior and impulse control. It was discontinued on 5/27/86. The progress notes are not on the ward record that far back and the reason for its elimination is therefore not apparent.

Dietary supplements were started 5/9/86. The annual physical on 6/20/86 stated the individual was underweight, but this in itself is not an indication for dietary supplementation.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: The progress note on 10/22/86 stated the patient cannot control leg movements and physical incoordination poor secondary to medication. The former is an akathisia reaction, one of the extrapyramidal reactions to the antipsychotics, which is difficult to control. It is being treated with trihexyphenidyl at this time.
5. Dosage: All dosages appear to be within acceptable limits. The antipsychotic could have been administered once daily.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 6/20/86. There is a diagnostic and treatment conference dated 10/9/79, a social history update dated 5/19/84, and a psychological evaluation dated 4/15/83. Physician progress notes have been written monthly during the last four months which are present on the ward chart. During this time appropriate changes in medication were made to address a gradual deterioration followed by an acute episode. Stability has been reestablished at this point.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present.

INTEGRATION: Not documented.

COMMENTS: The most recent physical examination was located under the laboratory tab.

Number: 32238
Admission: 4/28/72
Site: Minimum 85
Birthdate: 7/20/56

Diagnosis: Schizophrenia, paranoid type
Left external strabismus
Medications: Benztropine (Cogentin)
Selenium sulfide shampoo
(Selsunn)
Aluminum and magnesium
hydroxide (Maalox)
Cimetidine (Tagamet)
White petrolatum (Vaseline)
Chlorpromazine (Thorazine)
Trifluoperazine (Stelazine)

HISTORY

1. Medication: Not documented.

Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.

Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Chlorpromazine and trifluoperazine are antipsychotic agent used to suppress some of the manifestation of schizophrenia, in particular eliminate the voices. Usually it is not necessary to use two antipsychotics concurrently but in this case the patient is stable and doing well on this regimen for quite some time. On 1/14/86 the dosage of trifluoperazine was decreased slightly and in 4/17/86 the dosage of chlorpromazine was decreased slightly. It would have been better to decrease the dosage of one agent rather than both in the hope of getting back to a single agent.

Benztropine is an anticholinergic agent used to suppress the extrapyramidal side effects from the antipsychotic agents.

Selenium sulfide shampoo is used to control dandruff although this is not specifically documented in this case.

Aluminum and magnesium hydroxide neutralizes acid in the stomach and cimetidine prevents secretion of acid into the stomach. This suggests some ulcer or other GI problem but none is documented.

White petrolatum is a greasy ointment usually used to prevent drying. It was applied to the feet, but the exact indication is not documented.

2. Contraindications: None documented.

Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.
 5. Dosage: All dosages appear to be within acceptable limits. The antipsychotics could have been administered once daily.
 6. Prescriber: Clearly identified.
 7. Review: The most recent physical exam was dated 6/3/86. The most recent mental status report was dated 4/26/83. There is a social history addendum dated 3/25/85. Physician progress notes have been written monthly during the three months of progress notes located on the ward chart.
 8. Goals: Specific goals of drug therapy are not documented.
 9. Patient Education: Inappropriate.
 10. Medication Record: Present.
- INTEGRATION: Not documented.

Number: 45917
Admission: 9/3/86
Age: Minimum 86
Birthdate: 3/21/53

Diagnosis: Schizoaffective psychosis
Mixed personality disorder
with hysterical, borderline
and dependent traits
Dry skin

Medications: Fluphenazine decanoate
(Prolixin)
Fluphenazine (Prolixin)
Trihexyphenidyl (Artane)
L-tryptophan
Temazepam (Restoril)
Dietary supplement (Sustacal)
Vitamin A and D ointment
(A and D)

HISTORY

Medication: Documented on the medical history and the diagnostic conference and psychiatric evaluation; but no details are provided.

Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.

Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

Indications: Fluphenazine is an antipsychotic agent used to treat some of the manifestations of schizophrenia. The decanoate is a long acting injectable form. It is appropriate to use this dosage form as the interim social history suggests that medication noncompliance had something to do with the readmission.

Trihexyphenidyl is an anticholinergic agent used to prevent extrapyramidal side effects from the fluphenazine.

L-tryptophan was ordered on admission as needed for sleep but was never received. Temazepam was used later to help insomnia for a short period. It is quite effective on a short-term basis.

Vitamin A and D ointment was used to treat dry skin.

2. Contraindications: None documented.

Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits. The oral fluphenazine could have been administered once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was not dated. Physician progress notes have been written frequently during the first couple of months after admission. It appears some progress at control is beginning to show. The diagnostic conference and psychiatric evaluation and interim social history were dated 9/9/86.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 38507
Mission: 4/21/86
Site: Unit 86
Birthdate: 5/08/55

Diagnosis: Schizophrenia, chronic
paranoid 295.31
error of refraction
Obesity, slight

Medication: Haloperidol (Haldol)
Trihexyphenidyl (Artane)
Aspirin

HISTORY

Medication: Not documented.

2. Allergy/Adverse Drug reaction: The patient has multiple allergies to antipsychotic medication which are appropriately documented. However, an allergy to codeine is documented on the treatment plan (as Tylenol #3) and the medication administration record (as codeine) which does not appear on the outside of the chart or on the physician order sheet.

3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic medication which is used for the treatment of the symptoms of schizophrenia. There are progress notes which suggest that the present regimen is not altering the patient's severe thought disorder. Trihexyphenidyl is an anticholinergic agent used for the suppression of extrapyramidal side effects associated with antipsychotic agents. The agent is being used continuously despite the lack of documentation of such effects; its need should be reassessed. This is important in this patient who demonstrates poor compliance with medication. The aspirin is being used for the relieve of pain on an as needed basis.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented, including extrapyramidal reactions associated with the haloperidol.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 1/27/86. The most recent mental status report was dated 4/29/83. Physician progress notes and medication review have been written at least monthly.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present 7/86 to present

INTEGRATION: Not documented.

Number: 49336
Admission: 9/24/86
Weight: Maximum 56
Birthdate: 1/21/60

Diagnosis: Mixed personality disorder

Medications: Triamterene and hydrochlorothiazide (Dyazide)
Dicloxacillin (Dynapen)
Milk of magnesia with cascara
Bisacodyl suppositories
(Dulcolax)
Psyllium (Metamucil)
Carbamide peroxide (Debrox)
Aspirin

HISTORY

Medication: Documented on the medical history which stated none but an RN progress note on 10/2/86 identifies a medication.

Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.

Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

Indications: Triamterene and hydrochlorothiazide is a combination of diuretics used in this case to treat hypertension. It was not ordered on admission as it was missed on the medication history. When it was identified by an RN on 10/2/86 because the patient asked about it, it was withheld and the blood pressure monitored. It was started on 10/9/86 when it became apparent that he did indeed need it.

Milk of magnesia, cascara, bisacodyl and psyllium are all used to treat constipation.

Carbamide peroxide is an eardrop used to help remove excess wax. Dicloxacillin is an antibiotic used to treat an infection in the right ear.

Aspirin is an analgesic and anti-inflammatory which was ordered as needed and has been used quite a lot in the last month.

Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits.

Prescriber: Clearly identified.

Review: The most recent physical exam was dated 9/24/86. Physician progress notes have appeared three times since admission.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Diagnosis: Bipolar Affective Disorder,

manic	294.40
-------	--------

Alcohol abuse, episodic 305.02

Possible partial complex

seizures

Foot callouses

Medication: Lithium carbonate

Valproic acid (Depakene)

Thioridazine (Mellaril)

Dr. Scholl's foot powder

Medication: The medication taken on admission are documented on the admission history & physical; no other medication history is available.

Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.

Drug Abuse: Documented on the medical history.

Indications: Lithium carbonate is effective in the treatment of bipolar disorder and the patient has received the present dose for some time. Valproic acid is an anticonvulsant which is effective in the treatment of seizure disorders including partial complex seizures. This patient's seizure disorder is recently diagnosed (6/86) and notes from that community hospitalization are not available; there is no description of the seizures and 2 factors are present in this patient (alcohol & antipsychotic use) which could cause seizures. It appears the need for anticonvulsants in this patient should be evaluated. This would appear to be especially helpful in this non-complaint patient. Thioridazine is an antipsychotic agent which is being used to control the psychotic features associated with the patient's bipolar disorder. While the chronic use of antipsychotics in the treatment of mania is not recommended, this patient clearly deteriorates when he becomes non-compliant with his medication and a noticeable improvement was noted with the last increase in the thioridazine dose. The Dr. Scholl's foot powder is used to improve foot hygiene.

2. Contraindications: Antipsychotic agents may lower the seizure threshold; however, this is a relative contraindication and at present, the patient's seizure disorder is controlled.

3. **Drug Interactions:** No specific adverse drug-drug interactions are apparent.

7. **Adverse Drug Reactions:** Antipsychotic agents and alcohol may lower the seizure threshold and result in seizures in susceptible patients and a community hospitalization from 7/11/86 notes that the patient's seizures are exacerbated by antipsychotic agents; no details are available. The patient chronically has an elevated white blood cell count and this is a documented associated effect of

lithium therapy.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 7/18/86. The most recent mental status report was dated 7/30/86. Physician progress notes and medication review are written at least monthly. The treatment plan is not correct regarding the current medication regimen. Serum lithium concentrations are checked monthly and valproic acid levels are checked every 3 months, both are within acceptable limits.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 7/86.

INTEGRATION: Not documented.

Number: 27667
Admission: 1/21/65
Site: Unit 85
Birthdate: 3/16/47

Diagnosis: Schizophrenia, chronic
undifferentiated 295.92
Enuresis
Hypertension
Hx: seizure disorder, Tonic-clonic

Medication: Haloperidol (Haldol)
Imipramine (Imipramine)
Benztropine (Cogentin)
Atenolol (Tenormin)
Hydrochlorothiazide
Prazosin (Minipres)
Phenobarbital
Phenytoin (Dilantin)
Acetaminophen
Aspirin
A & D ointment

HISTORY

Medication: Not documented.

Allergy/Adverse Drug reaction: An allergy to sulfa is documented in all locations; no mention is made of past adverse drug reactions.

Drug Abuse: Not documented.

CURRENT MEDICATIONS

Indications: Haloperidol is an antipsychotic agent used in the treatment of the symptoms of schizophrenia. Benztropine is an anticholinergic agent used for suppression of extrapyramidal adverse effects frequently associated with haloperidol; the agent is being used continuously despite a lack of documentation of extrapyramidal effects. Imipramine is an antidepressant agent which has been used to treat enuresis; any value is attributable to an anticholinergic effect from the agent. However, its value for enuresis in the adult patient is not well substantiated and this patient is already receiving an anticholinergic agent (Benztropine). Hydrochlorothiazide is a diuretic, prazosin is a vasodilator, and atenolol is a centrally acting antihypertensive medication; all of these agents are being used in the treatment of hypertension. The doses of the agents suggest the combined agent approach is necessary in this patient, but no history is available. Phenobarbital and phenytoin are anticonvulsants used in the treatment of seizure disorders including tonic-clonic type. Acetaminophen and aspirin are available on an as needed basis for mild pain and the A&D ointment is used for dry irritated skin.

2. Contraindications: Both haloperidol and imipramine can lower the seizure threshold and this would be of concern in a patient with a seizure disorder. This does not appear to be causing

problems in this patient, but the use of imipramine should be evaluated for the reasons stated above.

3. Drug Interactions: The concurrent use of phenobarbital can enhance the metabolism of phenytoin and increase elimination.

4. Adverse Drug Reactions: The patient was noted to be consuming large quantities of water prior to an admission to Galen and this effect could be partially attributable to an excess anticholinergic effect (dry mouth) from the combined use of benztropine and imipramine.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 6/8/86. The most recent medical status report was dated 8/4/82. Physician progress notes and medication review have been written at least monthly. The treatment plan is correct for the current medication regimen. Blood pressures are monitored frequently and phenobarbital and phenytoin serum concentrations are monitored monthly. Serum levels of both agents were noted to be quite low, suggesting that monotherapy with one agent may be effective; there is no good history regarding the patient's seizure disorder in the chart.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 7/86.

INTEGRATION: Not documented.

Number: 37392
Admission: 9/9/78
Unit: Unit D
Birthdate: 9/5/57

Diagnosis: Schizophrenia; chronic
undifferentiated 295.9
Drug dependence 304.8
Spastic colon

Medication: Loxapine (Loxitane)
Benztropine (Cogentin)
Acetaminophen
Aspirin
Therapeutic vitamin

HISTORY

1. Medication: Not documented.

Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in all appropriate locations in the chart.

Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Loxapine is an antipsychotic agent which controls the symptoms of schizophrenia. Fixed delusions and auditory hallucinations apparently are always present to some degree; however, the medication is documented to have a beneficial effect in decreasing the severity. Benztropine is an anticholinergic agent which suppresses extrapyramidal adverse effects often associated with antipsychotic agents. The agent is being used continuously although no extrapyramidal symptoms are documented and loxapine is an agent less likely to cause such symptoms. Evaluation of the necessity of the therapy is important since the patient has poor compliance with medication. The aspirin and acetaminophen are used on an as needed basis for mild pain. The therapeutic vitamin is a nutritional supplement and the patient is noted to be underweight.

2. Contraindications: None documented.

Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: The dose of loxapine recently was lowered in consideration of excessive lethargy in the patient in the early morning.

Dosage: All dosages appear to be within acceptable limits.

Prescriber: Clearly identified.

Review: The most recent physical exam was dated 3/6/86. A social history was dated 8/12/86. Physician progress notes and medication review are written at least monthly. There was no recent mental status exam.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 8/86

INTEGRATION: Not documented.

Number: 36893

Admission: 8/3/86 (4th admit)

Unit: Unit D

Birthdate: 11/6/59

Diagnosis: Schizophrenia, chronic

paranoid 295.32

Alcohol abuse 305.01

S/P Cholecystectomy

S/P back surgery

Medication: Trihexyphenidyl (Artane)

Trifluoperazine (Stelazine)

Disulfiram (Antabuse)

A & D ointment

HISTORY

1. Medication: Not documented.

Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in appropriate locations within the chart.

Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Trifluoperazine is an antipsychotic which ameliorates the symptoms of schizophrenia; it was used following lack of benefit from perphenazine (Trilafon) and adverse reactions from chlorpromazine (Thorazine). Trihexyphenidyl is an anticholinergic agent which suppresses extrapyramidal reactions which often are associated with antipsychotic agents. Symptoms suggestive of extrapyramidal reactions (rocking) are noted but not attributed to adverse reactions in the progress notes. Disulfiram is a therapeutic adjunct used in the treatment of alcoholism. A & D ointment is being used to treat dry skin associated with sunburn in the patient.

2. Contraindications: The need for continuous anticholinergic agent should be assessed in consideration of the poor medication compliance by the patient.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: A sunburn as a result of photosensitivity attributed to antipsychotic agents was present. A itchy rash was noted on 10/19/86 on the stomach region and could represent an adverse effect of either antipsychotics or disulfiram. Chlorpromazine was discontinued because of adverse effects which included decreased blood pressure as well as those mentioned.

Dosage: All dosages appear to be within acceptable limits.

Prescriber: Clearly identified.

Review: The most recent physical exam was dated 8/3/86. An interim social history was dated 8/5/86 and a psychiatric evaluation was dated 9/16/86. The treatment plan was accurate with the current medication regimen and monthly reviews are being performed.

8. Goals: Specific goals of drug therapy are not documented

9. Patient Education: Inappropriate

10. Medication Record: Present since 8/86.

INTEGRATION: Not documented.

Number: 34822

Admission: 2/9/80 (5th admit)

Site: Unit D

Birthdate: 8/15/46

Diagnosis: Schizophrenia,

schizoaffective 295.7

stress incontinence,

associated with coughing

Medication: Haloperidol (Haldol)

Trihexyphenidyl (Artane)

Lithium carbonate

Acetaminophen

Aspirin

HISTORY

1. Medication: Not documented.

2. Allergy/Adverse Drug reaction: Allergies are documented as no known allergies in all appropriate locations in the chart.

3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent which is useful in the treatment of the symptoms of schizophrenia. Lithium carbonate is used in combination with antipsychotic for the treatment of schizoaffective syndromes. Trihexyphenidyl is an anticholinergic agent which suppresses extrapyramidal adverse effects associated with antipsychotics. It is being used on a continuous basis in the patient although no such reactions are documented. The acetaminophen and aspirin are being used in the treatment of mild pain and are used as needed. The anticholinergic effect of trihexyphenidyl may be beneficial in this patient with incontinence since the agents are associated with urinary retention. Oxybutynin (Ditropan) and furadantin (Macrodantin) have been tried unsuccessfully in the treatment of stress incontinence and surgery is now recommended.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: An elevated white blood cell count may be attributable to prolonged lithium therapy.

5. Dosage: All dosages appear to be within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 6/2/86. The most recent social history report was dated 8/13/86. Physician progress notes and medication review are written at least monthly. The treatment plan is current with regard to the present medication regimen. Lithium serum concentrations are measured every 3 months and are within normal limits. There was no

recent mental status exam.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present since 6/86

INTEGRATION: Not documented.

Diagnosis: Schizoaffective disorder

295.72

Borderline Personality

disorder 301.83

Alcohol abuse 305.02

S/P suicide attempts

S/P removal sebaceous cyst

9/30/86

Medication: Perphenazine (Trilafon)

Benztropine (Cogentin)

Doxepin (Sinequan)

Ibuprofen (Motrin)

Aspirin

Acetaminophen

Therapeutic vitamin with

minerals

PhisoHex

Basis soap

STORY

Medication: Documented on the medical history, but no details are provided.

2. Allergy/Adverse Drug reaction: An allergy to sulfa is documented appropriately in locations of the medical chart.

3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Perphenazine is an antipsychotic which controls the symptoms of the schizoaffective disorder, including auditory hallucinations present in this patient. Benztropine is an anticholinergic which suppresses extrapyramidal adverse effects often associated with the use of antipsychotic agents. Doxepin is an antidepressant which controls depression associated with the schizoaffective disorder in this patient. Doxepin also has moderate anticholinergic potency which would help suppress extrapyramidal reactions. Extrapyramidal adverse effects are not documented in this patient despite the use of the anticholinergic agent on a continuous basis; the continuing need in this poorly compliant patient should be reassessed. Also, it appeared that an increase in depression signs (10/7) has followed a decrease in the dosage of the doxepin. Ibuprofen is a non-steroidal anti-inflammatory and analgesic agent which is being used in the treatment of menstrual cramps and the aspirin and acetaminophen are being used for minor pain. The therapeutic vitamin with minerals is a nutritional supplement and the need in this patient is not clear. Phisohex and Basis soap are adjuncts for facial hygiene in this patient who has had a sebaceous cyst removed.

Contraindications: None documented, but poor compliance with medication is noted.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Antacids were used a couple of times following administration of ibuprofen, suggesting some gastrointestinal distress associated with the ibuprofen
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 9/11/86. The most recent mental status report was dated 9/19/86 and appears within the medical progress notes. Monthly medication review and physician progress notes are written at least monthly.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present since 9/86.

INTEGRATION: Not documented.

Number: 28152
Admission: 7/27/71
Site: Warren 41
Birthdate: 12/20/46

Diagnosis: Schizophrenia, paranoid type
Grand mal epilepsy
Dry Skin
Medications: Phenobarbital elixir
Lithium carbonate
Multiple vitamin (Stresstabs)
Phenytoin suspension
(Dilantin)
Procyclidine (Kemadrin)
Dietary supplement (Sustacal)
Haloperidol concentrate
(Haldol)

HISTORY

1. Medication: Not documented.

Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.

Drug Abuse: Not documented.

CURRENT MEDICATIONS

Indications: Phenobarbital and phenytoin are anticonvulsants used to suppress seizure activity. A transfer note from Galen dated 2/21/86 states "Dilantin is also questionably in use". No seizure record is present to document the frequency of seizure activity. The serum concentrations of both agents have recently been somewhat low. These agents are consistent with the diagnosis of grand mal epilepsy but whether or not there is continued need for both drugs is not apparent.

Another problem with the phenytoin is the use of the suspension. The suspension is very thick and difficult to resuspend. Therefore, it is necessary to shake the bottle vigorously for a full five minutes before each use. It is highly unlikely that anyone would do this routinely. If the drug is not resuspended adequately the top of the bottle contains less drug and the patient receives less than prescribed while the bottom of the bottle contains more drug and the patient receives more than prescribed. After a dosage increase in November 1985 the serum concentrations at first ran 4.9, but without a dosage change have since been reported at 5.4, 6.2, and 6.3. It would be interesting to correlate the top vs bottom of the bottle with these serum concentrations.

Haloperidol is an antipsychotic agent used to suppress the manifestations of paranoid schizophrenia. Lithium is apparently also used for this purpose. It is sometimes useful in schizophrenia for controlling specific symptoms, but the exact target symptoms in this case is not clear on the record.

Procyclidine is an anticholinergic agent used to suppress the extrapyramidal side effects of haloperidol. The dosages of both the haloperidol and the procyclidine have been stable for several

months. Since there is no documentation of continuing side effects, it would be prudent to taper the anticholinergic and discontinue it. Usually it can be stopped after three months without side effects returning.

There is no documented indication for either the multiple vitamins or for the dietary supplement.

2. **Contraindications:** Seizures are a relative contraindication to the use of any antipsychotic agent. Since the frequency of seizures is not documented it is not possible to assess if any problem has manifest in this case.

3. **Drug Interactions:** No specific adverse drug-drug interactions are documented.

4. **Adverse Drug Reactions:** None documented.

5. **Dosage:** Lithium serum concentrations have been within the therapeutic range. The dosages of phenobarbital and phenytoin are somewhat low based on serum concentrations, but may be adequate—one cannot tell if seizures are adequately controlled without a seizure record. The use of phenytoin suspension often presents uneven dosages (see indications). All other dosages appear to be within acceptable limits.

6. **Prescriber:** Clearly identified.

7. **Review:** The most recent physical exam was dated 7/21/86. The most recent mental status report was dated 9/16/85. Physician progress notes have been written irregularly; there is a gap between 5/1/86 and 10/23/86. The most recent social history update was dated 10/2/86. No seizure record is present.

8. **Goals:** Specific goals of drug therapy are not documented.

9. **Patient Education:** Inappropriate.

10. **Medication Record:** Present.

INTEGRATION: Not documented.

Number: 20763 Diagnosis: Mental Retardation
Admission: 11/24/81 Chronic undifferentiated
Age: Maximum 57 schizophrenia
Birthdate: 11/4/29 Probable Myocardial infarction
 Old pityriasis rosea
 Medications: Thiothixine (Navane)
 Mesoridazine (Serentil)
 Trihexyphenidyl (Artane)
 Temazepam (Restoril)
 Selenium sulfide shampoo (Selsun)

STORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Thiothixine and mesoridazine are antipsychotic agents which would help to control schizophrenic manifestations. It appears in this case that their primary use is to control assaultive behavior. The mesoridazine was substituted on 6/11/86 for the thiothixine because of minimal response of the assaultive behavior.

Trihexyphenidyl is an anticholinergic agent used to suppress extrapyramidal side effects from the antipsychotic agents. The dosage of the antipsychotic has been stable since 6/11/86. Usually it is not necessary to continue the anticholinergic for more than three months. Since there is no documentation of continued side effects the dosage of the anticholinergic should be tapered and discontinued. Mesoridazine is also less likely to cause these problems than most agents.

Temazepam is an hypnotic agent which was used on three occasions for short periods in August and September. Its indication is not documented but it is most likely to have been used to help resolve a sleep problem. These agents can be very useful for short periods.

Selenium sulfide shampoo is used to control dandruff. Dandruff is not a documented problem.

Aspirin was used as needed for pain. There have been frequent complaints of chest pain which are relieved with aspirin. Heart problems have been ruled out on numerous occasions with electrocardiography.

1. Contraindications: None documented.
2. Drug Interactions: No specific adverse drug-drug interactions are documented.
3. Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits. A serum thiothixine concentration was done on 5/27/86 which was in the usual range. The antipsychotic could have been administered once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 3/5/86. The most recent mental status report was dated 11/30/86. Physician progress notes have been written every one or two months in 1986. A treatment plan review was dated 4/17/86. The social history update was dated 5/20/86. Despite this attention the impulse control and temper tantrums are less than adequately controlled.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 20063

Admission: 5/30/84

Attending: Spratt 21984

Birthdate: 4/21/15

Diagnosis: Schizophrenia, paranoid,
chronic

Labile Hypertension

Exogenous obesity

Right cataract with impaired
vision

Lipoma, right forehead

Indigestion

Medications: Haloperidol (Haldol)

Benztropine (Cogentin)

Docusate calcium (Surfak)

Pentoxifylline (Trental)

Bacitracin ointment

Aluminum and magnesium

hydroxide with simethicone

(Mylanta)

HISTORY

Medication: The medication question on the medical history form was not filled out; the form was not dated.

Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.

Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

Indications: Haloperidol is an antipsychotic agent used to suppress the manifestations of schizophrenia particularly in this case paranoia and delusions. Benztropine is an anticholinergic agent used to treat extrapyramidal side effects from the antipsychotic agent. Its continued use is justified as the recent physical exam (7/10/86) and a progress note (7/25/86) which document continuing side effects.

Pentoxifylline decreases blood viscosity and stabilizes red blood cell membranes. Its approved indication is for intermittent claudication which is not documented in this case. It has also been used in some cases of cerebrovascular insufficiency to improve psychological symptoms. An EEG on 6/14/84 does suggest cerebrovascular insufficiency. The exact indication or target symptom is not documented.

Bacitracin ointment is an antibiotic ointment for topical use. It was applied to the right toe presumably for some injury or sore. It was discontinued on 6/8/86.

Aluminum and magnesium hydroxide with simethicone is an antacid used to control indigestion as needed.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented
4. Adverse Drug Reactions: Extrapyramidal side effects from haloperidol were documented in the physical exam on 7/10/86 and the psychiatrist progress note on 7/25/86. This has been treated with benztropine.
5. Dosage: All dosages appear to be within acceptable limits. The serum haloperidol concentration was within the usual range on 8/21/85. The dosage schedule of benztropine was changed at the patients request. The antipsychotic could have been administered once daily.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 7/10/86. The most recent mental status report was dated 12/10/85. Physician progress notes have been written monthly. A treatment plan review was dated 5/30/84. A diagnostic conference and psychiatric evaluation was dated 6/11/84. A social history update was dated 2/24/86. This person has been on haloperidol for two years at both higher and lower dosages than currently but yet continues delusional. A thorough review of past psychotropic use is needed to identify therapeutic options which might help control the delusions.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 37780
Admission: 7/19/82
Site: Spratt 219
Birthdate: 2/150

Diagnosis: Organic Personality Syndrome
Seizures
Aphasia
Hemiplegia
S/P Auto accident
Incontinent of urine & feces
Medications: Mesoridazine (Serentil)
? (Doxidan syrup plus)
Phenobarbital
Selenium sulfide shampoo
(Selsun)
Cetyl alcohol-coal tar
distillate, salicylic
acid and sulfur ointment
(Pragmatar)
Carbamazepine (Tegretol)
Lotion (Alpha-Keri)
Diphenhydramine and calomine
lotion (Caladryl)
Triamterene and hydrochloro-
thiazide (Dyazide)
Hydrochlorothiazide

HISTORY

1. Medication: The medication question on the medical history form is not filled out.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record and the nursing intake; no mention is made of past adverse drug reactions. The medical history form refers on to old records which are not located on the ward.
3. Drug Abuse: The medical history refers one to old records.

CURRENT MEDICATIONS

1. Indications: Mesoridazine is an antipsychotic agent used to help control striking out aggressive behavior. It has not been very successful. Carbamazepine is an anticonvulsant which was added to the regimen on 7/30/86 to help control the aggression. It did help but because of suspected increase in heart size it was discontinued. The chest x-rays on 7/5/83 and 7/27/84 before the carbamazepine was started demonstrated slightly enlarged and upper limit of normal heart size. The chest x-ray on 8/1/85, also before carbamazepine, read moderate cardiac enlargement. The one chest x-ray since beginning the carbamazepine showed enlarged transverse diameter on 9/4/86. The only electrocardiogram on the chart was 10/2/86 which was read as nonspecific T waves with somatic interference. According to a nurse on the unit the patient has never had symptoms of overt heart failure. Carbamazepine has demonstrated effectiveness in this patient and since its role in the enlarged heart is questionable, it seems prudent to reinstitute this drug

and monitor for cardiac effects with symptoms, electrocardiogram and chest x-ray.

Triamterene and hydrochlorothiazide is a combinations of diuretic agents which was prescribed on 9/30/86. Its exact indication is not documented. One possibility might be heart failure secondary to carbamazepine as discussed above but this is not supported by the nurse. The physician's progress note of that date refers to the chest x-ray suggesting that it is these changes which are being treated and not symptoms. On 10/7/86 the diuretic was changed to hydrochlorothiazide alone at a lower dosage. There is no documentation as to the reason for this change.

Phenobarbital is an anticonvulsant used to suppress the seizure disorder.

Doxidan syrup plus does not exit. We can assume this is a stool softener and stimulant laxative combination used in the management of constipation. Is the stimulant contributing to the fecal incontinence?

Pragmatar ointment was used for a lesion on the right arm. The exact nature of this lesion is not described. It was discontinued on 6/30/86. On 9/25/86 alpha keri lotion and diphenhydramine and calomine lotions were ordered to apply to a lesion on the right arm tatoo. Diphenhydramine has some anti-itch properties when used topically.

Selenium sulfide shampoo is used to control dandruff. Dandruff is not documented in this case.

2. Contraindications: All anticonvulsants are relatively contraindicated in the presence of a seizure disorder. There is no seizure record therefore it is impossible to assess if any problems have become manifest.

3. Drug Interactions: Phenobarbital and carbamazepine are likely to affect the rate at which the other is eliminated. Serum concentrations should be monitored closely and dosages adjusted as needed.

4. Adverse Drug Reactions: Drowsiness and lethargy are documented in the progress notes on 9/17/86 and 9/18/86. Initially the dosage of mesoridazine was decreased but this led to agitation. Then the carbamazepine was adjusted.

5. Dosage: All dosages appear to be within acceptable limits. Phenobarbital and carbamazepine serum concentrations have been within the usual therapeutic limits. The antipsychotic could have been administered once daily.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 9/25/85. The most recent treatment plan review was dated 9/17/85. Physician progress notes have been written monthly or more frequently during the past few months. The most recent psychiatric evaluation was dated 7/29/82. The most recent social history update was dated 12/9/85. Liver function tests , complete blood counts, chest x-rays and electrocardiograms were appropriately monitored while on carbamazepine. No

electrolyte have been done since starting on the diuretic but should be.

8. Goals: Specific goals of drug therapy are not documented

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 49375
Admission: 10/8/86
Site: Spratt 219
Birthdate: 5/24/28

Diagnosis: Schizoaffective disorder

Medications: Mesoridazine (Serentil)
Benztropine (Cogentin)
Temazepam (Restoril)
Haloperidol (Haldol)
Fludrocortisone
Fluphenazine (Prolixin)
Fluphenazine decanoate
(Prolixin)
Clonazepam (Klonopin)

HISTORY

1. Medication: Documented on a progress note dated 6/11/86.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Mesoridazine, haloperidol, and fluphenazine are all antipsychotic agents used sequentially for control of delusions, wandering, and yelping. The change from mesoridazine to haloperidol was because of side effects. Fluphenazine was substituted for haloperidol because the haloperidol was not working and there was a history of response to fluphenazine. The history of noncompliance justifies the use of the long acting injection, fluphenazine decanoate.

Clonazepam is an anticonvulsant which was added to the regimen to help control the behavioral disturbances. There is also a past history of response to this agent.

Temazepam is used to aid sleep for a brief time after admission. This agent is very useful for this purpose for limited periods.

Fludrocortisone is a hormone which was used to treat the low blood pressure problems caused by the antipsychotic agents.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Hypotension secondary to the antipsychotic agents is documented on several occasions (10/8/86, 10/9/86, 10/21/86). This was a continuing problem which was adequately managed with fludrocortisone.
5. Dosage: All dosages appear to be within acceptable limits. The dosage of the antipsychotic

could have been administered once daily.

Prescriber: Clearly identified.

7. Review: No recent physical exam was present on the chart. Ten physician progress notes have been written this first month. A new drug regimen has just been instituted, it is too soon to tell if it will be effective.

Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Not present on the chart on the ward. This is the first month of this admission and presumably the medication administration record is located with the current ones on the medication cart.

INTEGRATION: Not documented.

Number: 13656	Diagnosis: Catatonic schizophrenia
Admission: 8/11/39	
Site: Spratt 219	Medications: Trifluoperazine (Stelazine)
Birthdate: 11/2/22	Thiothixine (Navane)
	Benztropine (Cogentin)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medication administration record; no mention is made of past adverse drug reactions.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Trifluoperazine and thiothixine are both antipsychotic agents used to suppress some of the manifestations of schizophrenia. Trifluoperazine has been used for several years but the dosage could not be reduced without loss of control. On 9/24/86 thiothixine was substituted because the patient was "increasingly resistive, less participation, apathetic and drowsy". On 10/15/86 the patient was put back on trifluoperazine because of the loss of control.

Benztropine is an anticholinergic agent used to prevent and treat extrapyramidal side effects from the antipsychotics. On 9/12/86 it was changed to as needed, but because of stiffness it was changed back to a regular schedule on 10/1/86.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Stiffness and in a daze was documented on 10/1/86. This was appropriately assessed as an extrapyramidal reaction to the antipsychotic and resolved with benztropine administration.
5. Dosage: All dosages appear to be within acceptable limits. When thiothixine was substituted for trifluoperazine the dosage was one-third on a mg for mg basis even though one would anticipate a roughly equivalent dosage would be nearly twice as many mg as trifluoperazine. The dosage of the antipsychotics could have been administered once daily.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 7/10/86. The patient evaluation dated 2/24/84, a social history update dated 4/22/86 and a treatment plan 6/5/86. There have been eight physician progress notes in the past few months.
8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

Medication Record: Present.

INTEGRATION: Not documented.

Number: 36752
Admission: 3/24/86
Site: Warren 43
Birthdate: 11/10/43

Diagnosis: Chronic paranoid
schizophrenia
Medications: Fluphenazine (Prolixin)
Mesoridazine (Serentil)
Thiothixine (Navane)
Benztropine (Cogentin)
Trihexyphenidyl (Artane)
Diphenhydramine (Benadryl)

HISTORY

1. Medication: Documented on the medical history, but no details are provided except current dosage.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Fluphenazine, mesoridazine and thiothixine are antipsychotic agents used to suppress some of the manifestations of schizophrenia. Changes from one to another were made due to lack of efficacy.

Benzotropine, trihexyphenidyl and diphenhydramine were used to counteract the extrapyramidal side effects of the antipsychotic agents. Trihexyphenidyl was substituted for benztropine on 3/27/86. The reason for this change was not documented. Because of continuing tremulousness diphenhydramine was added on 4/17/86. Usually it is better to use an adequate dosage of one agent than to duplicate.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: Various extrapyramidal side effects from the antipsychotics were reported (3/24/86, 4/7/86, 4/17/86). These were only partially controlled with the use of anticholinergic agents.
5. Dosage: All dosages appear to be within acceptable limits. The dosage of the antipsychotic could have been administered once daily.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 3/24/86. The most recent diagnostic conference and psychiatric evaluation was dated 4/14/86. An interim social history was dated 4/10/86. Physician progress notes have been written at one to three month intervals in 1986. The patient is only moderately controlled.

9. Goals: Specific goals of drug therapy are not documented.

10. Patient Education: Inappropriate.

11. Medication Record: Present.

INTEGRATION: Not documented.

Number: 37760
Admission: 12/22/82
Site: Warren 43
Birthdate: 9/17/67

Diagnosis: Chronic undifferentiated
schizophrenia
Medications: Haloperidol (Haldol)
Benztropine (Cogentin)

HISTORY

1. Medication: Documented on the medical history, but no details are provided. This form was not dated.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent used to suppress some of the manifestations of schizophrenia and to control anger.

Benzotropine is an anticholinergic agent used to suppress the extrapyramidal side effects of the haloperidol. It is usually not necessary to continue the anticholinergic forever. Since the dosage of the antipsychotic has been stable for over three months and there is no documentation of continuing side effects, a trial without the benztropine is indicated.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented.
5. Dosage: All dosages appear to be within acceptable limits. The dosage of the antipsychotic could have been administered once daily.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 1/8/85. The most recent diagnostic conference and psychiatric evaluation was dated 4/22/86. An interim social history is dated 4/21/86. Physician progress notes have been written at intervals up to three months in 1986.
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 34059
Admission: 3/5/86
Site: Warren 42
Birthdate: 3/16/51

Diagnosis: Chronic undifferentiated
schizophrenia
Epilepsy
Medications: Lithium carbonate
Benztropine (Cogentin)
Phenytoin (Dilantin)
Thiothixine (Navane)
Perphenazine (Trilafon)
Diphenhydramine (Benadryl)

HISTORY

1. Medication: Documented on the medical history, but no details are provided. The medical history was not dated.
2. Allergy/Adverse Drug reaction: Allergies are documented on the medical history; no mention is made of past adverse drug reactions.
3. Drug Abuse: Documented on the medical history.

CURRENT MEDICATIONS

1. Indications: Thiothixine and perphenazine are antipsychotic agents used to suppress some of the manifestations of schizophrenia. Perphenazine was substituted for thiothixine on 7/2/86. The reason for this switch is not clear.

Benzotropine is an anticholinergic agent used to suppress extrapyramidal side effects from the antipsychotics. On 9/5/86 it was discontinued and diphenhydramine was started. The reason for this change is not documented.

Lithium was probably used to control behavior outbursts, although this is not clearly stated in the record.

Phenytoin is an anticonvulsant used to suppress the seizure disorder.

Contraindications: A seizure disorder is a relative contraindication to the use of any antipsychotic agent. Since there is no seizure record it is impossible to tell if the seizures have gotten worse since beginning antipsychotics.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: None documented.

5. Dosage: All dosages appear to be within acceptable limits. Serum phenytoin and lithium concentrations have been within the usual therapeutic range. The phenytoin and the antipsychotic could be given once daily rather than split, as could the antipsychotics.

6. Prescriber: Clearly identified.

7. Review: The most recent physical exam was dated 7/1/86. There is a psychological report update dated 10/6/86, a diagnostic conference and psychiatric evaluation dated 3/27/86, and an interim social history dated 3/29/86. Physician progress notes have mostly been removed from the ward record; only one dated 8/7/86 remains. There is no seizure record.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

COMMENT: The physical exam was filed under miscellaneous. The treatment plan on the cardex stated Navane on 10/23/86 even though it was discontinued on 7/2/86.

Number: 34513
Admission: 10/1/86
Site: Warren 42
Birthdate: 8/31/50

Diagnosis: Chronic undifferentiated
schizophrenia
Mild mental retardation
Alcohol and marijuana abuse
Dementia associated with
alcohol

Medications: Mesoridazine (Serentil)
Benztropine (Cogentin)
Multiple vitamin

STORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Not documented.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

Indications: Mesoridazine is an antipsychotic agent used to suppress some of the manifestations of schizophrenia. Benztropine is an anticholinergic agent used to prevent or treat extrapyramidal side effects from the mesoridazine. It was started on 10/23/86. There is no documentation as to the exact problem which resulted in this prescription. Mesoridazine is an agent which is less likely to cause these types of side effects.

There is no documented indication for the multiple vitamin.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented.
5. Dosage: All dosages appear to be within acceptable limits. The antipsychotic could be given once daily rather than split.
6. Prescriber: Clearly identified.
7. Review: Since admission there has been three notes from the psychiatrist (10/1/86, 10/3/86, 10/9/86).
8. Goals: Specific goals of drug therapy are not documented.
9. Patient Education: Inappropriate.
10. Medication Record: Present.

INTEGRATION: Not documented.

Number: 31729
Admission: 3/22/78
Site: Warren 42
Birthdate: 6/7/51

Diagnosis: Chronic undifferentiated
schizophrenia
Medications: Maprotiline (Ludiomil)
Methyl salicylate and menthol
(Analgesic Balm)
Sulindac (Clinoril)
Cyclobenzaprine (Flexeril)
Ibuprofen (Motrin)
Lorazepam (Ativan)

HISTORY

1. Medication: Not documented.
2. Allergy/Adverse Drug reaction: Not documented.
3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Maprotiline is an antidepressant which was used apparently to manage a depression even though this is not documented in the record. It was discontinued on 7/18/86; the accompanying progress note stated the individual was symptom free for six months. This is an appropriate action.

Methyl salicylate and menthol ointment was used with heat to treat a shoulder pain. The exact nature of this pain is not documented. Sulindac is an anti-inflammatory and analgesic agent which was used for elbow and shoulder pain. It was discontinued on 9/30/86.

Ibuprofen is another analgesic and anti-inflammatory agent prescribed on 10/2/86 for backpain. It was continued for 10 days.

Cyclobenzaprine is a muscle relaxant used to treat spasm in the right lumbar paravertebral muscles. It is quite effective for short term used in this type of disorder. It was prescribed for a four day period on 10/7/86. On 10/5/86 lorazepam was also prescribed for back spasm. Although this agent is effective for short-term use, it is associated with a high incidence of sedation. It was and is used as needed.

2. Contraindications: None documented.
3. Drug Interactions: No specific adverse drug-drug interactions are documented.
4. Adverse Drug Reactions: None documented.
5. Dosage: All dosages appear to be within acceptable limits.
6. Prescriber: Clearly identified.
7. Review: The most recent physical exam was dated 3/6/86. The most recent mental status

report was dated 4/13/83. The most recent interim social history was dated 4/13/78 and the most recent evaluation and treatment conference was dated 4/11/78. Physician progress notes have mostly been removed from the chart; there are psychiatrist notes dated 7/18/86 and 7/25/86.

8. Goals: Specific goals of drug therapy are not documented.

9. Patient Education: Inappropriate.

10. Medication Record: Present.

INTEGRATION: Not documented.

COMMENTS: The treatment plan on the cardex lists ludiomil even though it was discontinued three months ago.

APPENDIX B
CONSULTANT ROSTER

Robert Bateen, Ph.D	Clinical Psychologist Helena, Montana
William Docktor, Pharm D	Clinical Pharmacist Missoula, Montana
Dianne Gitlin, RN,MS	Nursing Specialist Missoula, Montana
Mike Rivey, Pharm D	Clinical Pharmacist Missoula, Montana
Frank Seitz, Ph.D	Clinical Psychologist Bozeman, Montana
Marrienne Spitzform, Ph.D	Clinical Psychologist Bozeman, Montana

*Resumes available upon request

APPENDIX C
MONTANA STATE HOSPITAL RESPONSE

RESPONSE TO THE MENTAL DISABILITIES BOARD OF VISITORS REPORT

MONTANA STATE HOSPITAL

OVERVIEW AND STAFFING

DEFICIENCIES:

1. We most certainly concur with the Board's concern over the number of treatment staff vacancies, but contend that the problem cannot be attributed to lack of trying or to forcing vacancy savings by deliberately holding positions open. Despite exhaustive recruitment efforts, significant vacancies continue in key areas. As of this date, the following positions remain vacant:

Psychiatrists: 4.0 F.T.E.

One of these vacant psychiatrist positions is being covered by a psychiatrist provided under contract with Comp Health.

There has been considerable adjustment to psychiatrist salaries which has resulted in an increased interest in psychiatrist positions at Montana State Hospital. A psychiatrist has been interviewed for the position of Clinical Director, and currently, we are negotiating salary and other benefits with him; hiring him in the near future looks very positive. We also are processing references and will be scheduling interviews for one or two persons interested in staff psychiatrist positions. Further, a psychiatrist will be joining our staff on July 1, 1987, through the National Health Service Corps Program.

Psychologists: Ph.D. Level 2.0 F.T.E.
M.A. Level 1.5 F.T.E.

A psychology resident under contract from the University of Montana provides service twenty hours per week; a contract was recently approved with Montana State University who will provide a predoctoral psychology intern for three months on a full time basis beginning in June.

Only one inquiry was generated through our most recent nationwide advertising. Salary adjustments may have to be considered in order to enhance recruitment efforts.

Registered Nurses: 3.5 F.T.E.

There is a possibility that 3.5 registered nurses will be employed within the month; at least, interest has been indicated and we are scheduling interviews.

Dieticians: 2.0 F.T.E.

We have received no applications from recent nationwide advertising and may have to consider contracting part-time services with local dieticians.

- (1) Shortages have not resulted in an increase in injuries to patients and staff. In fact, we have seen a reduction in these incidents; in example, incidents have decreased by 50% on the Extended Treatment Unit.
- (2) Concur.
- (3) We have not noted an increase in average length of stay. Available statistics do not support this premise; in example, the number of admissions and discharges on the Warm Springs Campus have remained essentially the same during fiscal years 1985 and 1986, while the average daily population in fiscal year 1985 was 334 and decreased in fiscal year 1986 to 302.
- (4) Concur.
2. Note previous comments under response to first deficiency.
3. Concur.
4. Following presentations from two firms, it is our opinion that contracted pharmacy services will provide more cost effective and much improved services over what we have the capability of providing even if fully staffed, specifically in the areas of unit dose drug distribution, continuing education and staff consultation programs, drug utilization reviews, drug profiles, quality assurance programs, and generation of immediate, daily, and monthly reports.
5. The scenario throughout the report references the need of inservice training. The key to effective inservice training programs lies in supporting individuals to increase their own motivation, aptitude and to help them develop more effective performance skills. Individual supervisors must define problems and, if a training solution is tantamount to solving the dilemma, then seek assistance and/or resources. Staff Development, under this type of management approach, is a continuing investment in personnel, the hospital and its patients. Funds have been provided by the Department of Institutions through the Institutional Training Program which has provided the opportunity for multidisciplinary staff to attend programs which are related to treatment issues as well as ancillary services. An increase in this funding would allow more staff to attend treatment training programs.

There is a program of the nature suggested by the Board in place on the Forensic Unit which is functioning well. Four special duty aides meet with a clinical psychologist for four hours monthly for direct training and supervision in psychotherapy, and an additional one hour monthly for private, individual supervision. Special duty aides rotate every six to nine months allowing this learning opportunity to each special duty aide.

6. Understanding and dealing with behavior problems is covered in all orientation programs for direct care nursing staff, as well as in preparation classes for advancement. Numerous video tapes are available for independent study on this subject.

On December 2, 1986, a program on "General Head Injury" was presented by Mark Ashley, Neuro Skills Clinic, Bakersfield, California, sponsored by the General Reinsurance Company. Sixty-one persons attended this program which was videotaped and is part of our current library.

Young adult schizophrenic programs are available through the video library. The program that will be presented on April 14 and 15 in Missoula will be attended by eleven multidisciplinary staff members who, in turn, will be asked to share with coworkers.

Basic classes are periodically presented in all referenced areas; however, because the Staff Development Department employs only 1.6 F.T.E., the clinical supervision of the individual's application and performance must be the responsibility of professional staff on the units.

At this point in the legislative process, we have received committee recommendation for an additional 29.90 F.T.E. (direct care nursing, psychology, rehabilitation staff) upon completion of the new forensic treatment facility. In addition, we anticipate being able to provide additional psychiatrist and social worker staff from our current level authorized positions.

7. This problem will be somewhat remedied when full psychiatrist staffing is achieved; however, it may always be necessary to pull certified mental health professionals from other units for review and justification of restraint/seclusion, especially during the 11:00 p.m. to 7:00 a.m. shift where, commonly, registered nurses are newly employed and lack the experience requirements for limited certification.

We are considering some organizational changes which, in long-range planning, may alleviate this problem.

8. Concur.
9. Concur.

TREATMENT SERVICES

DEFICIENCIES:

10. Admittedly, psychotherapy, both individual and group, is minimal and is offered primarily to those patients most in need. This deficit is due to the lack of psychiatrists and clinical psychologists to serve as primary therapists and to provide staff education and clinical supervision. This deficit cannot be attributed to staff cutbacks since there has been no reduction in authorized professional staff; the problem, as addressed in our response to the first deficiency, is the inability to fill critical vacant positions.

As indicated in our response to the fifth deficiency, a psychotherapy program with clinical psychologists providing staff training and supervision has been initiated on the Forensic Unit. Further, group psychotherapy is conducted by a professional psychologist twice weekly on that unit.

11. The problem in developing treatment programs specific to the needs of the young chronically mentally ill is being addressed. In our response to the sixth deficiency, we have indicated that staff will be attending an educational program this month and will, hopefully, acquire information which can be presented to staff at the hospital and will assist us in program development. Additionally, if we succeed in our present negotiations and are able to fill the clinical director's position, we anticipate that new and innovative therapeutic modalities will, in time, emerge through that person's leadership, direction, and psychiatric expertise.
12. Our response to the eleventh deficiency is applicable here as well. Further, we have knowledgeable, qualified staff assigned to the chemical dependency programs at the Galen Campus who can provide education and assistance to both patients and staff at the Warm Springs Campus. Better utilization of this valuable and readily available resource will be pursued.
13. This is a highly specialized area and, as such, requires a new program with specially trained and qualified staff and separate housing which, in our opinion, would also require a major financial commitment.
14. Improvement in treatment plans is continually addressed. Restructuring of the utilization review process, which is under consideration at this time, may facilitate this; however, recruitment and utilization of key professional staff in meeting this need is critical. This issue has been more specifically addressed in our responses to deficiencies 1, 2, 5, 10, 11.
15. The patient to whom you refer has severe medical, neurological, and psychiatric problems, the gravity of which create management problems and raise treatment issues beyond any we have previously encountered. She has been evaluated numerous times; evaluations have included the full range of neurological tests.

Most recent complete medical, neurological and psychiatric examination was done at our request at Billings Deaconess Hospital under the primary care of Joseph D. Rich, M.D., in August, 1986. Following that hospitalization, the patient was returned to Montana State Hospital, Galen Campus, with the recommendation that she be "managed in the best way possible so as to allow her to live out her final days with some semblance of comfort and gratification.....there is no treatment which will lead to her recovery, and this is a continual progressively and deteriorating neurological disorder which will be undoubtedly terminal for her."

We have attempted care and management of this patient on both campuses. Her condition rapidly deteriorates even more when she is placed at Warm Springs. It is our opinion, and one that is shared by Dr. Rich, that her condition worsens in a stressful, disruptive, noisy environment; in fact, she reacts negatively at times to even the slightest stimulation. The

decision to place her at Galen was based upon the aforementioned, which is clearly justified when comparison is made of the patient's reactions and responses in both environments.

ADMISSIONS _ PLACEMENT

DEFICIENCIES:

16. Concur.
17. Concur.
18. This problem has been addressed in presentations to groups seeking understanding of Montana State Hospital and the Admission, Discharge Review Team. Representatives from the private psychiatric facility responsible for the two voluntary admissions referenced here were in attendance during one of those presentations; no further problems of that type have occurred.
19. Legislative consideration is presently being given to amending the section of Montana law concerning the admission of youth to Montana State Hospital.

CONSUMER ISSUES AND PATIENT RIGHTS

DEFICIENCIES:

20. (1) Restraint/Seclusion Policies and Procedures are part of a continuing training program for employees; in example, they are covered in all direct care nursing staff orientation programs and reviewed in special duty aide preparation classes. Reinforcement classes are held yearly; seven classes were held in 1986 with a total of fifty employees in attendance. In addition, cassette tape programs are available for review of crisis intervention techniques; a review of the restraint/seclusion policies was held in August, 1986, and was completed by two hundred and twenty-one employees.
- (2) This is currently provided in the restraint/seclusion policy; reference procedure 4.

"The physician and unit supervisor shall be informed of the progress of any patients currently restrained or secluded or who have been restrained or secluded during their off duty hours. This will occur beginning their regular tour of duty."
- (3) This is currently provided in the restraint/seclusion policy; reference procedure 2.

"The physician's order must state the reason and justification for restraint/seclusion. 'Protection of self and others' is not acceptable."

- (4) This is currently provided in the restraint/seclusion policy; reference section on TYPES OF RESTRAINT/SECLUSION.

"Restraints utilized are to be used from least to most restrictive in all situations. Authorization for the type of restraint to be utilized is to be decided upon by sound clinical judgement and so documented by a physician's order and a certified mental health professional's progress note."

- (5) This is partially addressed in the restraint/seclusion policy; reference section on INTERPERSONAL RELATIONSHIPS.

"All steps of the restraint process are to be explained to the patient including justification as to why the procedure is being used as well as explaining to the patient the requirements for the restraint to be terminated."

The restraint/seclusion policy will be revised to reflect that the aforementioned must be documented.

- (6) Immediate review is already provided in Montana Law (53-21-146 MCA) and in hospital policy "RESTRAINT/SECLUSION". This review must be done in all cases within one hour and does not, nor should it, require request from the patient. Further review is required when restraint/seclusion is continued beyond twenty-four (24) hours. Additional review occurs when the intervention report is forwarded to the Restraint and Seclusion Review Committee.

Another mechanism for review is provided through the Patient Grievance Procedure. All patients are advised of this procedure and have, in fact, used it for this purpose.

- (7) Note response to (6).

21. General Fund appropriation in the next biennium for replacement of furniture has been requested.
22. This is currently provided in the supportive restraint policy; reference procedure 2, 8.

"An order for supportive restraint is valid for thirty days from the date it was written and signed. Indication of need for restraint shall be reviewed by the physician each time the order is renewed."

"When long-term supportive restraint is necessary, regardless of the reason for the restraint, a referral will be sent to the Restraint/Seclusion Review Committee to review such restraint. Long-term restraint will be defined as fifteen days continuous restraint in any thirty day period. If the Restraint/Seclusion Review Committee determines that the supportive restraint is appropriate and should be continued, it need not again be

referred to the committee unless such review is requested by the unit supervisor or physician or a periodic review is requested by the Restraint/Seclusion Review Committee."

further review on the Galen Campus is accomplished through care plan conference assessment and care review.

23. We fully support this suggestion and will, when time and staff availability allows, develop an information pamphlet.
24. This has been suggested by the Board in earlier reports. We have investigated this matter and have not arrived at any suitable solution.
25. Approval for the use of long-range building appropriations for construction of a fenced area was obtained in the current biennium. We are awaiting notification to proceed with the project from the Division of Architect and Engineering.

General Fund appropriations in the next biennium for a whirlpool tub has been requested.

26. We are unsure on how to address this deficiency since we removed any reference to senile aged from all documents long ago. We will certainly caution staff on the absolute necessity of avoiding the use of "retarded" or "senile aged" in either verbal or written communications.

ENVIRONMENTAL

DEFICIENCIES:

27. The sixteen inch long tear in the flooring between the dining area and the lounge in the day hall on Crockett I is the result of an expansion joint that is located between these two areas. The constant movement of that expansion joint causes the edge of the floor to chip away. This happens over an extended period of time to the point that the area chipped away is eventually necessary to repair. We have not found a satisfactory material to fill this crack that will withstand the constant movement of this floor. We have had several engineers, including the Architectural and Engineering Division of the State of Montana, look at this area and they have not been able to recommend a permanent fix. Consequently, we are forced to repair this on an as needed basis. The last repair done in this area was November 11, 1986. An inspection of the area on this date reveals that there are few other small chips that will also need to be repaired in the near future. We will continue to do this repair on a somewhat irregular basis as required until a permanent solution is found.
28. Montana State Hospital submitted its request through the Long Range Building Program to the Central Office and, consequently, to the State Legislature. Included in this request, as Items Number 24 and 35, were requests for energy retrofit to provide for insulation on the steam pipes as well as

energy retrofit for the Short Term Unit. We have also submitted requests through the Department of Natural Resources under an energy grant program for funds to provide financing for both of these projects. We have not heard back from UNRC yet as to the success of our request. There are three programs under the Department of Natural Resources for which these projects could qualify. We have applied for funding under all three programs.

29. The potential safety and fire hazards existing in the kitchen area have been remedied through scheduling. The exhaust and hoods over the grills in the kitchen are cleaned after each use which will eliminate any potential fire hazard. The cleaning of floors, to include corners, is accomplished daily. Oven tops in the kitchen are also cleaned daily. Arrangements have been made with the maintenance supervisor and the housekeeping supervisor to ensure that all light fixtures in the food center and the oven tops in the bakery are cleaned on a regularly scheduled basis.
30. The bathrooms on the east end of the Multipurpose Building receive considerable usage. These bathrooms are cleaned daily at approximately 3:00 p.m. In order to provide more coverage, we have rescheduled our staff so that, effective immediately, the bathrooms will be cleaned at approximately 12:00 noon and again after 5:00 p.m. The bathrooms on the east end were scheduled for renovation in conjunction with our renovation of the coffee shop located across the hall. Renovation on bathrooms started on 4/8/87 and included the replacement of lighting fixtures as well as the fixtures on the sinks. Other minor items in the area are also being replaced. The area is being completely repainted following that renovation. The renovation is expected to be completed on 4/17/87.
31. Requests have been made through the Long Range Building Program for the renovation of the showers and bathrooms on the Short Term Unit. We are requesting \$48,600 to provide that renovation. We are well aware that the area needs additional ventilation. The humidity in that area causes the paint to peel and chip quite frequently. Regardless of whether the funding is provided, we will be repainting the bathing areas the first part of May, 1987.

RECORD KEEPING

INTRODUCTORY COMMENTS:

There are currently 14.10 F.T.E. employed in the consolidated Medical Record Department: 1.0 Medical Records Administrator, 6.0 F.T.E. assigned to the Warm Springs Unit, 7.10 F.T.E. assigned to the Galen Unit including 1.50 receptionist positions.

The issues raised by the Board as potential problems simply do not exist. In fact, just the opposite has occurred through reorganization of the Department.

1. Productivity in filing, discharge analysis and coding has improved 100%. The loose filing has been completely caught up on several occasions.

2. On the Warm Springs Campus, employee morale was at an all time low and productivity was poor. All employees have indicated improvement in morale and "it's fun to come to work now." Employees are proud of the accomplishments that have been made, and they certainly should be. They now know their jobs and do them well.
3. The superior quality of the supervision and direction now being provided makes up for the lack of full time supervision on both campuses. Employees who are satisfied in the work environment, understand their job responsibilities, and respect management expectations require less direct supervision.

DEFICIENCIES:

32. This issue has addressed in our responses to Deficiencies 1, 2, 5, 10, 11, 14.
33. This deficit has markedly improved with an adjustment in the responsibilities of the word processing operators, streamlining of admission and diagnostic records, and new word processing equipment. Utilization Review reports and backlog reports are indicative of this improvement.
34. Concur.
35. It is our opinion that aggressive medical leadership will eliminate problems such as those enumerated by the Board. We are optimistic that will be achieved if negotiations with the person interested in the clinical director position are successful.

The Board's suggestion to develop a flow sheet for assessment and documentation of medical problems is worthy of serious consideration and will be discussed with the medical staff.

36. This issue has been addressed in our response to Deficiency 35.
37. This issue has been addressed in our responses to Deficiencies 5, 6, 20.
38. This issue is partially addressed in our response to Deficiency 14. Hospital Policy "TREATMENT PLAN" clearly identifies those few entries which are to be made in pencil; only those entries may be erased. Date of initial plan and dates of review and updates do not fall within those few exceptions. Instructional updates for appropriate staff members will be implemented. In addition, it will be reemphasized to professional staff members that they are expected to carry out their responsibilities in approving and supervising development and implementation of the treatment plan.
39. Social histories are updated on an annual basis and are located in the care plan folders. The care plan folder is part of the patient's permanent record. Some of our patients do not have legal guardians, nor do they have family. Limited guardianship has not been established except to the extent that, when required for surgical consent or similar type authorizations, the superintendent is appointed by the court.

MEDICATION

DEFICIENCIES:

40. Note our responses to Deficiencies 4, 35. The development of a medication history format will be explored with the clinical director, medical staff, and the firm awarded the pharmacy contract. Ideally, this information should be developed as part of the patient profile and should, most appropriately, be programmed into the pharmacy computer program.
41. The following comments were received specific to some of the cases cited by the Board in this deficiency:

Virginia Hill, M.D.

No. 37780 - A careful review reveals the psychotropic medications are all indicated. This patient suffered a significant head trauma with multiple medical and psychiatric sequela. Within the past year, he had one grand mal seizure when his anticonvulsants were withdrawn. The Phenobarbital was then reinstated. He has had several partial complex seizures since then until Tegretol was added for control of seizures and aggressive behavior. As aggressive and sexually inappropriate behaviors were still disruptive, Mellaril was continued as it is one of the least seizure-genic neuroleptics. We are aware of the potential for adverse drug reactions, and monitor the patient's drug levels and clinical status on a daily basis.

No. 37661 - This patient demonstrates an unusual pelvic thrusting gait that has puzzled our neurology consultant. He is receiving only psychoactive drugs for his psychotic condition which has been repeatedly described throughout the chart.

No. 20763 - This patient's agitated, delusional and striking out behavior is documented throughout the progress notes and treatment plan, supporting a very well defined indication to use psychotropic medications; in example, to decrease psychosis.

Steven Shirilla, M.D.

No. 46682 - This patient has had frequent changes in her anticonvulsant medications with the impossibility of controlling her behavior and poor results in controlling her seizures because of the patient's noncompliance in taking medication.

Gary Lord, M.D.

No. 13798 - This patient is unable to give a meaningful history. The patient's management is based upon consultation with the orthopedist who originally placed the prosthesis.

42. Insofar as feasibly possible in view of the serious shortage of staff psychiatrists, weekly medication reviews are being done. This review by the psychiatrists and physicians is indicated on the Medication Administration Record (MAR). We contend, however, that a more comprehensive, meaningful review and improved documentation of each patient's medication

regime would occur if this review were required monthly and became an integral part of the total, multidisciplinary review process. A thirty-day medication review is consistent with regulations of Medicaid and JCAH. Attempts have been made to amend the Statute, Section 53-21-145, MCA, through the legislative process.

The following comments were received specific to some of the cases cited by the Board in this deficiency:

Virginia Hill, M.D.

No. 49375 - This patient was admitted October 8, 1986, and a physical examination was done and has always been present in the medical record.

Steven Shirilla, M.D.

No. 37760 - The patient's physical examination was completed and is dated February 22, 1985. He was hospitalized only three days on the Galen Campus.

43. Comments were not received specific to this case. We will request review of this case as soon as possible during utilization (care) review.
44. On the Galen Campus, the use of anticholinergics is addressed on a regular basis during care reviews with nursing staff, physicians and pharmacist; this review is reflected in the care review notes which are signed by the physician. Many patients have been taken off these medications on a trial basis without success.

On the Warm Springs Campus, the use of anticholinergics is addressed daily during the intake process, weekly during medication review by the attending psychiatrist or physician, and quarterly during treatment plan review, or more frequently as the specific need arises.

The following comments were received specific to some of the cases cited by the Board in this deficiency:

Virginia Hill, M.D.

No. 37346 - Without anticholinergic medication, this patient exhibits incapacitating upper extremity tremors which interfere with her ability to feed herself.

No. 37044 - The physician who admitted this patient recognized her history of schizoaffective disorder and acute depression which had culminated in a suicidal gesture. Goals of treating a depression and preventing a psychotic relapse are self-evident. Details of specific doses of Mellaril, Thorazine, or Haldol were not a priority on admission. The patient has a long noncompliance history, and Cogentin was continued to enhance compliance with Trilafon. Young people are particularly at risk for EPS. Past intolerance to other neuroleptics is not a primary concern of this patient's current admission.

No. 49208 - This patient refused to give his medical history at the time of admission. When more cooperative, he was unable to recall medications he had taken in the past. The patient's drug abuse history is documented in the social history. The patient suffered significant extrapyramidal side effects with stiffness, cogwheel, rigidity, and drooling on both Navane and Haldol despite adequate trials of Artane, Symmetrel, and Cogentin alone and in various combinations. These symptoms were not as distressing with Loxitane, but in view of his extremely poor medication compliance history, his male sex, and young age, continuing Cogentin was indicated. Loxitane is mid range in its ability to produce EPS. A patient's responses to neuroleptics are not static, and future trials of Haldol or Navane are not medically contraindicated. Efforts to obtain the physical examination were refused. The specific goals of drug treatment are repeatedly documented in the progress notes and treatment plan. The patient was educated on a daily basis concerning his need for psychotropics to correct distorted thinking and prevent hospitalization.

No. 37392 - This patient had his physical examination on March 25, 1987. It is likely he refused last year's physical examination as this is his pattern. Current mental status examination is also documented. Medication history is in the main file. This patient has been here since 1978, and I have assumed his care since July, 1986, and am unaware of an adverse reaction to Haldol. Education is difficult in this regressed, chronically delusional patient. Drug abuse behaviors are documented in the social history. Loxitane renders this patient less hostile and aggressive, but has not resolved his delusional concerns. Again, Loxitane is mid range in its ability to produce EPS. This patient is a young male which puts him in a higher risk category for experiencing EPS. However, tapering of Cogentin is underway as recent EPS documentation is not available.

No. 36893 - The admitting physician elected to refer to the patient's main file for medication history. The goals of drug treatment have been repeatedly reiterated: severe agitation, paranoia, and religious delusional concerns. The patient has exhibited upper extremity tremors and akinesia which is lessened with anticholinergics. As listed in the patient's treatment plan, the patient's education regarding medication is conducted on an as needed basis when it is appropriate.

No. 34822 - This patient has exhibited upper extremity tremors which are helped with Artane. Her mental status examination continues to document delusional, tangential, and insightful behavior. Psychoactive drugs have been unsuccessful in decreasing her thinking derangement, but resistance, belligerence, and aggressive tendencies have responded to Lithium and Haldol.

45. The following comment was received specific to one of the cases cited by the Board in this deficiency:

Steven Shirilla, M.D.

No. 46682 - It has been our longstanding experience with this patient that the amount of seizure medication presented to the patient and the amount that the patient actually takes are not necessarily related. We have vast swings in her anticonvulsant levels because of her noncompliance in taking

the medication and it made the decision that the best course of action for us in this patient is to give the patient a regular dose and not to seesaw up and down in dosages when the major problem is that the patient is not taking a regular dose.

In regard to Case No. 28152, review of this case will be requested.

46. Administration of antipsychotic drugs, specifically in terms of number of times administered per day, will be reviewed by the clinical director.
47. Recommendations for timely monitoring of drug levels have been prepared and disseminated as of early 1986. Regarding the time of draw, our new slips for the TDX instrument incorporates this feature, so this problem should be eliminated. Most standard procedures, however, call for the levels being drawn at the trough, which is 7:00 a.m., immediately prior to the next dose. Policy and procedure regarding this issue are currently enforced.
48. In regard to Cases No. 34822 and No. 37044, note Dr. Hill's response to Deficiency 44.
49. This deficit will be addressed when the contract for pharmacy services is awarded.

In summary to the deficiencies cited in this section "MEDICATION":

Harry Xanthopoulos, M.D.

"In response to the Board of Visitor's Report, I am sure the deficiencies cited regarding medical services are legitimate. However, due to the shortage of psychiatric staff at Montana State Hospital at the present time, it is not possible to comply with the recommendations made in this report. If Montana State Hospital should recruit sufficient psychiatrists, it would then be feasible to comply with the suggested recommendations.

I note that the Board of Visitors does not have a physician or psychiatrist on the Board. I would like to recommend that consideration be given by them to include a physician or psychiatrist on the Board in order to more thoroughly understand and evaluate the current medical practices at Montana State Hospital."

Virginia Hill, M.D.

"I would like to suggest to the Board of Visitors that a board certified psychiatrist, having had experience in state hospital policy making and treatment, would be an invaluable addition to the review team. I do not feel this was truly a peer review. We are not treating textbook cases at this facility, and I do not agree with most of the criticisms offered."

